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UNIVERSITY OF NORTH CAROLINA
EXTENSION BULLETIN

VOL. XV JULY, 1935 NO. 1

# PLAY PRODUCING

## FOR SCHOOL AND LITTLE THEATRE STAGES

BY FREDERICK H. KOCH
AND STAFF MEMBERS OF
THE CAROLINA PLAYMAKERS

CHAPEL HILL MCMXXXV
THE UNIVERSITY OF NORTH CAROLINA PRESS

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¶ *(Above)* THE PLAYMAKERS THEATRE on the campus of the University of North Carolina, Chapel Hill, the home of The Carolina Playmakers. The first theatre building in America to be dedicated to a native drama of its own. *(Below)* THE FOREST THEATRE of The Carolina Playmakers. The stage setting for A MIDSUMMER NIGHT'S DREAM, directed by Professor Koch, at right.

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# A CAROLINA PEOPLE'S THEATRE

In the fall of 1918 when the formation of The Carolina Playmakers was planned at Chapel Hill, the Bureau of Community Drama was organized in the Extension Division of the University to encourage the producing of plays in the schools and towns of North Carolina. More than this, it has been our hope from the first to create an active interest in the writing of original folk-plays drawn from the native folk life.

From these simple beginnings a remarkable renaissance in the drama has come. Today there is acting and playwriting everywhere in our Carolina country, in high schools, colleges, and little theatres from the Great Smoky Mountains to the sea.

The formation of our state-wide Carolina Dramatic Association, twelve years ago, made secure the foundations of a real people's theatre in North Carolina. The rising tide of dramatic endeavor was unchecked by the hazards of the devastating financial crisis. The Twelfth Annual Festival and State Tournament of the Association, held in The Playmakers Theatre at Chapel Hill in March, was a thrilling adventure for all of us. The Festival was truly a dramatic revival. Three hundred and fourteen (314) players and directors presented thirty-one (31) plays (eleven of them original). Many of them brought their own scenery and properties. Some of them traveled hundreds of miles. And more than 3500 people attended the Festival.

Through the generosity of one of the Foundations last year we were able to make available to the state the services of an Extension Instructor in Dramatic Arts, Mr. John W. Parker, Playmaker alumnus. The whole state became his campus. During the year he drove more than thirty thousand miles in assisting teachers in developing dramatics in the schools and in training directors for towns and country communities all over North Carolina. During the year he conducted five classes in Play Production, with a total enrollment of one hundred and fifty (150) students (mostly teachers), representing over sixty (60) towns and communities. The students received regular University credits, applicable toward a degree or toward renewing or raising teaching certificates.

More and more we are coming to realize the importance of dramatic training. The theatre in some form or other has always been cherished by the people. And it always will be, because the play instinct is born in every child. It is really an expression of his creative impulse—of a desire to create his own world. It is a natural impulse which makes the boy want to don a cowboy or an Indian costume for a wild west show. His stage may be an attic or a barn, and he will charge an admission fee of ten pins, perhaps, to the theatre which he has created. The little girls, less commercially minded, will make up their plays, put on their mothers' old dresses and hats, and act out scenes imitating their elders at home.

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The educative value of dramatic training will be felt in a new appreciation of human values, in a better use of spoken English, a deeper appreciation of the best in literature, in a self-control and freedom of expression—an invaluable asset in any walk of life. It will do much to relieve the monotony of everyday life; it will provide refreshing entertainment for the entire community; it will help to redeem the drab commonplace of a workaday world. For recreation—*re-creation* is essential in the life of man.

With the increase of leisure time has come a greater need for constructive recreation. The theatre is irresistible. The people will have it. Important as they are, the movies are not enough. We need a theatre in which the people will have an *active* part—a People's Theatre! Such a theatre, rightly organized and directed, will contribute not a little in the formation of a real American culture.

Chapel Hill, North Carolina
September 4, 1935

—*Frederick H. Koch.*

PART I

# ORGANIZING THE DRAMATIC GROUP

*By* Frederick H. Koch

In preparing for the production of a play, most people give little thought to planning a practical working organization. A High School senior class, a group of money-raisers interested in some benevolent project, or young folks just "in for the fun of the thing," decide to "get up a play." There is no serious purpose, no artistic standard, nor any careful planning for a worthy production as an end in itself. And the work of all devolves upon one or two faithful enthusiasts who must collect properties, work the lights, make-up the actors, act themselves, and attend to everything which is to be done. The other members of the cast attend rehearsals when they think they can spare time, and romp through the preliminary work to a harried performance which comes off somehow, by nerve-wracking last-minute effort. It seems quite a feat to have accomplished even a ragged performance after the thousand and one hitches.

To those who have been involved in such play production it is not necessary to point out the need for a simple orderly plan of organization. Its practical worth will be seen at once. But there will immediately arise this question: Can people be sufficiently interested actually to function as parts of a unified group? Can non-professionals take their work seriously, or be taken seriously by their audiences? The answer is "Yes." It cannot be stated too emphatically that the amateur group is capable of admirable creative work. But it is necessary first to dispense with the apologetic attitude and to take the producing of drama seriously. Then amateur performances need not be compared with professional work. For theirs will be a different standard—ultimately it may be a better one—the standard of those who play for the love of it.

There should be a serious purpose behind all dramatic work. It may do more than merely provide entertainment. It may be the means of giving expression to the creative talents of the community. Once the imagination is fired, once the aim is recognized as worthy of the best effort, there will be a community of striving toward the common goal in creative dramatic expression.

The danger of over-organization must be avoided. It is easy enough to select committees, but the working out of an organization on paper does not mean that a body has been created which will actually do the work of production. The organization of officers and committees need not be planned to spring up in full grown complexity to be imposed on the group. It should be a natural growth. The aim of the group need not even be formulated consciously in a written constitution. If there are a few willing to work patiently to interest others a working organization can be formed. The old traditions of

slip-shod amateur performances are strong, and the statement of serious artistic aims may seem formidable to those who have not tested their abilities. The one most gifted artistically is often timid and must be encouraged before he will attempt to paint a scene or try-out for a part. It has been found that frequently those who have least confidence in their ability at first, will make the most valuable contribution in the end.

A community organization should be democratic from the first. If a reputation for exclusiveness becomes established it will be difficult to interest those outside of the chosen clique. It should be the aim at the beginning to encourage all who have an interest in any department of theatre work. In a real community organization a member may be defined as anyone who contributes in any way to the production of the play.

## THE DIRECTOR

It is necessary, in order to obtain unity of aim and effort, that there be a single Director, or a Committee of Directors, who shall in turn bear the responsibility of the programs. The Director should consult the various committees as necessary. He should be the unifying force which sees the end in view and guides all toward it. He should keep in touch with all branches of the work, though he need not necessarily be an expert in all departments. He should be *ex-officio* member of all committees, and the final court of appeal in all differences which may arise. With the aid of the Play Committee he should supervise the selection of the play. After thorough competitive try-outs, he should select the actors, in consultation with a Cast Committee. He should have charge of all rehearsals, being assisted by the Prompter who may serve in the capacity of Assistant Director and receive the training which will fit him later on to assume the place of Director. Where there is a Committee of Directors, only one Director should train the actors for a given play. There is nothing more disconcerting than varying directions or interpretations, stage business, etc. Visitors at rehearsals should not be permitted. They tend to distract the attention of the players from the play.

## THE TECHNICAL STAFF

Whenever it is possible it is well to have a Technical Director for designing, constructing and painting the scenery and stage effects. If such a person is not available, the Director should appoint the heads of departments of scenery, lighting, properties, make-up, costuming, and music. These should confer. If all details of settings, lights, properties, etc., are first arranged by consultation of the heads of various departments under the supervision of the Director then the Property Master will not bring in a rose lamp-shade which "fights" with the heroine's orange dress. A Technical Staff consists of six heads of departments: the Stage Manager, the Electrician, the Prop-

erty Master, the Wardrobe Mistress, the Make-up Manager and the Musical Director.

## THE STAGE MANAGER

It is the duty of the Stage Manager to select and organize the stage crew. So as not to limit the number of this group, anyone who is interested in designing, building, or painting scenery should be encouraged to participate in the workshop activities. For the actual performance of a play, the Stage Manager may select those of the group who are most competent. Thus the members of the stage crew may vary from one performance to another.

The Stage Manager with his staff of workers is responsible for shifting the scenery, operating off-stage effects (thunder, wind, etc.), and pulling the curtain at the exact moment when the act begins and ends. The blame for long waits should rest on him. To avoid this he should not depend on the dress rehearsals but should call scenery rehearsals with all scenery, light appliances, and properties until his staff has learned to "strike a scene" with ease and orderliless. The property men may bring on the large articles of furniture while the walls are down and then add the smaller articles as the scenery goes up. At the same time the Stage Electrician can connect his extension cords and fixtures for lamp lights, lights on the back drop, windows, etc. The position of lights and properties is indicated on plots which should be carefully studied.

The plot of the scenery shows the position of the backdrop, walls, doors, windows, fireplaces, ground-rows, various backings, etc., and the backing for doors and windows.

The property plot shows the position of the furniture and lists this together with all small properties.

A light plot indicates the position and colors of lights on the "foots," sidelight strips, borders, etc. It should show where lamp lights are to be connected and the placing of lights for outdoor sunset and moonlight effects. It should indicate the line cues for dimming the lights, etc.

Long waits between scenes not only show "amateurishness" behind stage, but are liable to "lose the audience" for the players, who must play against wearied and exasperated hearers. It is absolutely necessary to have efficient organization behind stage. The Stage Manager should be an efficient leader who will work out all details and see that his staff constitutes a loyal, intelligent organization. He must not be one who will try to do all the work himself, but one who can be the brains of the work behind stage.

## SCENERY

Scenery is the background before which the play is performed. In designing and executing the settings for a specific play, care should be given to color and line so that the proper tone may be achieved.

The Stage Manager and his assistants have charge of constructing and painting the scenery. Wherever possible a space other than the stage itself should be devoted to this purpose, a workshop where the technicians may execute their effects, undisturbed by actors, rehearsals, and spectators.

## LIGHTING

The Stage Electrician is responsible for securing the light effects desired and for constructing all necessary fixtures. He should hold the light plot and, by attending rehearsals, become familiar with all cues which signal him to flash lights on or off, and to bring up the light which indicates that a lamp is being lighted or that the sunlight becomes brighter. He is responsible for contriving any light effects, such as fires, lightning, etc. In order to avoid the danger of fire, it is necessary that he himself, or an expert helper, operate all electrical appliances.

## PROPERTIES

The Property Master and his assistants are responsible for the collecting, buying, or making of all properties required. In most productions it is necessary to borrow furniture. Unless great care is taken of articles, the group will soon find it impossible to borrow the necessary settings. Therefore care must be taken in the hauling and in the *prompt return* of borrowed furniture. Wherever possible articles should be bought or made and preserved in the property box, or a room provided for costumes and properties. The Director of Properties should have a complete list of all properties needed and should consult with his committee, assigning the articles definitely to the various members. Choice of draperies, rugs, and colored articles should be worked out carefully, as suggested above, with the advice of the Costume Committee and the Director.

Where several one-act plays are produced on the same bill, it is a good plan to make one person responsible for each play. All details should be carefully worked out and listed. Without carrying realism to an extreme many effects may be easily had. Steaming water in the kettle over real flames may be had by using a can of "Sterno" set inside a pan to prevent accidents, and concealed in the stove or behind the logs in a fireplace. Many other small details may be arranged which will add much to the realism of a scene. An interested and ingenious group will devise valuable details of the production through a well-planned choice of "props."

In a program requiring more than one setting, it is well to assemble the furniture and properties for each setting in convenient order near the stage entrances. Small properties should be arranged on a table provided for the purpose. Articles used by only one actor, such as spectacles, a letter, a staff, or cane, are usually provided by the actor. They should be placed in a convenient place planned beforehand.

## COSTUMES

The Wardrobe Mistress with her staff should be ready to make or rent costumes for a period play and to direct the players in the selection of suitable dress for a modern play. With the help of the Director she should see that all the costumes harmonize, that the leading lady does not wear an elaborate frock as a country girl, and that the shades chosen by different actresses may not "fight" with other dresses or with the settings. The artistic ability and ingenuity of those interested in costuming should be stimulated by encouraging the designing and execution of the costumes for a period play. The expense need not exceed that of rented costumes. Beautiful and original effects (often better than is possible with rented costumes) may be obtained with inexpensive materials, old clothing and skillful use of dyes. By the proper composition and blending of colors and materials many beautiful costumes may be made. The dramatic group will acquire in this way, a considerable wardrobe—if proper care is taken of the home-made garments. The care of the costume room is under the supervision of the Wardrobe Mistress.

## MAKE-UP

Like all the other processes of dramatic art, successful make-up grows out of experience only. In every group there are usually several persons who are especially interested in the art. These, under the direction of the Make-Up Manager, should not limit their practice to the night of dress rehearsal, but should experiment frequently on one another or on the cast.

Each member of the group may be assigned to the character with which he has become most familiar in practice. Often one who is skillful in "straight" make-up fails in character work, which requires a knowledge of lines, wrinkles, and beards.

The Make-up Manager should be familiar with the play and the characterization, through attendance at rehearsals. He should keep the make-up box well stocked with the necessary materials. He should also take measurements for wigs and order them when needed. If wigs are bought by the group he should see that they are kept in good order.

Since the general principles and fundamental operations of make-up are not difficult to grasp, each actor should learn enough of the process to be able to make himself up for his own part. At the dress rehearsals, all make-ups should be carefully worked out and their effects tried before the stage lights.

## THE DIRECTOR OF MUSIC

The Director of Music arranges for music between the acts and for incidental music for songs, dances, etc., in the play. The music played before the curtain rises may do much toward getting the audience into the mood of the drama following. The Director should plan care-

fully for this and avoid such mistakes as rag-time before a slow tragedy, or a soft classical piece before a snappy little farce. Of course a professional orchestra may provide the music, but if there is a talented musician at hand it is best to turn over this part of the program to him, remembering that the larger the number of interested workers, the more thoroughly will the community be stimulated in the various inter-related arts of the theatre.

## THE BUSINESS MANAGEMENT

The Business Manager, though he has nothing to do with the production of a play, has everything to do with its success. For a play is not complete until it is performed before an audience, and the size and nature of the audience depends on the activities of the Business Manager. In addition to the advertising and general publicity, he should have supervision of everything in front of the foot-lights: the tickets, programs, ushers, etc. With the Director and the heads of the various committees, he should plan the budget for the productions. He pays the bills only after they have been properly approved by the heads of committees.

In planning a budget the following items should be considered: the material for stage equipment (especially that needed at the outset), rental of a stage (in some cases), royalties and copies of plays, construction of scenery, costumes, lighting equipment, make-up and wigs, drayage of the stage furniture, and properties.

It is well to purchase good materials at the outset, adding to the equipment. Lavish expenditure should be discouraged, but the group need not be so modest in its demands as to cripple its first performance. A simply staged program may be put on to raise money for equipment, or several interested citizens may be asked to underwrite the organization for the initial outlay. A dramatic organization will become self-supporting if properly managed.

## DIVISION OF RESPONSIBILITY

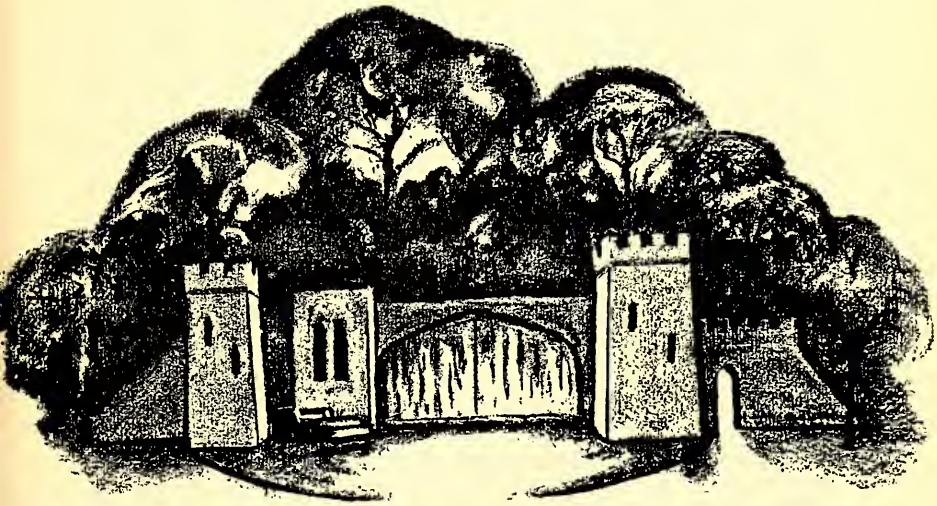
Only in exceptional cases should a worker "double" in different departments, at the same time. The work should be distributed. Actors, in particular, should not be encouraged to participate in stagecraft, business management, or other departments of the work.

A community dramatic organization should find and develop latent talent in all phases of production. No one part of the work can exist without the others. Each is important and worthy of the best effort of the artist, whether his part be scene-painting, publicity, or scene-shifting.

In the modern factory each worker toils over the making of a single small part of the whole machine. One man may spend all his days making one type of little cog wheel. His small contribution to the whole must, however, be perfect if the assembled machine is to be a perfect whole. Yet he may not catch the vision of the whole.

Through endless repetition of the same hum-drum "bit" all his creative interest is crushed. His work becomes mechanical and monotonous. It is the task of community recreation to restore to every worker his creative spirit. No form of activity is better adapted to such purpose than community effort in dramatic arts.

The aim of the communal theatre organization should be always thoroughly democratic. It should enlist the active cooperation of every person interested, whether he be employed in an office, a factory, or a store. It should unite all in a form of communal play, where all may work together toward a common end—creative expression. The person who cannot act may paint scenery, or become an invaluable aid in the construction of stage effects or even in stage management. A scene of individual initiative and accomplishment in the final production will elevate the humblest form of work to the plane of creative imagination.



*The setting for* "HAMLET" *by Samuel Selden. A drawing by Lena Alice Tuttle*

PART II

# PRODUCING THE PLAY

*By* Frederick H. Koch

## SELECTING THE PLAY

The choice of the play is of great importance, for the initial production will determine largely the working organization. If the play chosen is too difficult for beginners, if its stage effects seem formidable, the organization will fail to enlist the enthusiastic support of the players, the working staff, and the audience. A wrong impression at the outset will be difficult to overcome in succeeding performances. Therefore let the Director and his advisers exercise extreme care in choosing the first play. It is a good plan to appoint a Play Committee to read and make notes on a number of plays, some of which may be selected for future performance. Some groups will prefer to plan out the programs for the entire year.

In the case of the High School Dramatic Club, or of a study group, the selection of a play will probably be made when the plays for study are chosen by the members. Even in this case certain considerations should govern choice of a play for production.

The first matter to be decided will be the size of the cast at the disposal of the Director and the relative skill of the actors. To secure a fair trial for all who would like to act, and to discover just what unsuspected talent is available, the plan of preliminary try-outs has been found useful. Everyone who has any desire to act is invited to appear before a committee. Two or more may appear in a scene selected by the committee. Each member of the committee should keep an independent annotated record of the voice, range, bearing, appearance, and probable ability of the candidates. These notes may be formed into a card index which will record the acting personnel available. Thus the Director will not make the mistake of selecting *David Garrick*, *The Professor's Love Story* or *Beau Brummel*, before he is sure that he has an outstanding actor for the lead in such "one-man" pieces. If he finds he has several good character actresses he will feel ready to choose *The Neighbors*, perhaps, knowing that Mis' Abel, Mis' Trot and Grandma are at hand; and he will not force these same actors into "straight" parts in some play for which they are not fitted by their natural qualifications.

Before deciding finally on the play to be produced, especially the first play, the Director should be certain that he does not overtax the abilities of his Producing Staff. It will be well to begin with a long play using one set throughout, or two or three short plays, with simple settings and no elaborate off-stage effects. Even if the Producing Staff is eager to try a difficult piece, the Director must curb this enthusiasm until the group gains more experience. If a program of one-act plays is selected, and one setting is rather elab-

orate, he should try to place that one at the beginning of the program so that there may be sufficient time to set the stage beforehand. The settings of the others then should be as simple as possible so that the scene-shifting may not overtax.

The kind of performance desired will be another consideration. Some special occasion of celebration may govern the choice. An outdoor Shakespearean performance is most effective in the spring, especially at Commencement.

The audience should be carefully considered. What would be appropriate for a crowd of grown-ups would not be so pleasing to young folks. This should be especially borne in mind in selecting a play for school presentation. By all means make the program enjoyable to the audience and do not try to "educate" it too quickly. Avoid plays of very subtle characterization, those intended for sophisticated audiences. Choose the wholesome and genuine, which touch on a theme of universal appeal. Plays of recognized literary merit, like *The School for Scandal*, for instance, may be successfully done by an experienced group. *She Stoops to Conquer* is an admirable play for beginners, since it has excellent literary form, is not difficult to do, and is always popular.

If the expense of the performance is to be kept within limits, the problem of costumes and royalty must be considered. The old classics may be played without royalty, but the players must be costumed appropriately, according to the period. If a modern play is chosen the actors may wear their own or borrowed clothes. But modern plays of good quality are covered by copyright and usually require the payment of royalty. The amount ranges from five to fifteen dollars for a one-act play; and from ten to fifty dollars for a full length play.

Before deciding on a copyrighted play, the publishers *must* be consulted. Some plays, popular with stock companies, are not available for amateur performances. Others carry royalty charges which may seem prohibitive at first. If, however, the group takes its work seriously and develops an enjoyment of good drama, it will not be long before all will realize that *good* plays make for success, and should be paid for—just as electrical supplies or other equipment are paid for. The number of plays available to amateurs is growing. Playwrights are encouraged by the revenue they receive. Every amateur group must see the justice of giving the author his hire, and that promptly—thus helping, in a small way, to increase the production of worthy drama.

If royalty is to be avoided, choose classic plays or translations—plays which are not in the repertory of stock companies. Amateurs may offer to the public an important drama which is seldom seen because professionals cannot risk a large sum in experimentation with the public taste. Here the non-commercial group can stimulate sound

dramatic authorship. In its experimental theatre it can rival professional production, and in a different sphere.

Every community group should look forward to the encouragement of original composition among its members. In this way a new drama of native origin may be stimulated in every section of the United States. A national drama may spring up—a body of literature not merely local, but truly American—expressing the life of our people everywhere.

Special mention has been made of the one-act play. For the amateur group its worth can hardly be estimated. The short form is admirably adapted to non-professionals, since there is small danger of monotony in interpretation, opportunity for many to participate without a strain, and great variety of effects to be gained. It is difficult for an unskilled player to carry a long rôle through to the end with sufficient flexibility and variety. But a one-act play offers a chance for short vivid impressions which may be achieved by the unprofessional player. When a group is striving to represent the entire community in its working staff, three one-act plays may enlist the help of many more persons than the full-length play. More people are included in the casts and different committees may be assigned to the production of the different plays. Care should be taken, however, to form a pleasing combination of plays. One serious play should usually be included. In beginning original work, too, it is well to start with the one-act form. It is not so difficult to handle and there is less risk attendant on the production of one original play if it is short and standard pieces are included on the program. Thus gradually the group may raise the level of its work while retaining the loyal support of workers and audience.

## SELECTING THE CAST

The cast should be selected by the Director and the Cast Committee. The assignment of the parts must be disinterested and fair. For the time being personal feelings must be set aside. The Committee must earn the absolute confidence of the prospective actor so that a decision, even if it is a severe blow to his pride, may be accepted as just. This is a difficult standard for a community to attain, especially if the town is small and personal feelings strong. The Cast Committee should be chosen with utmost care. If those who know most about the coaching of a play are apt to be biased by previous experience or personal feeling, add to the Committee several whose judgment of acting is sound and whose opinions may be trusted, even if these persons have had no practical dramatic experience.

As described above, preliminary try-outs are a great aid in securing some knowledge of the candidates. In trying out for a given play, the Director should endeavor to stimulate competition in a natural un-self-conscious way. All candidates should have the opportunity to read the play in advance and to try-out in the scenes which

the Committee has selected as giving best demonstration of ability in the various rôles. These passages should be indicated in a number of copies of the plays which should be accessible to all candidates in advance. It is unfortunately true that many young people cannot read aloud in an intelligent way, when reading at sight. A test cannot really be fair, then, unless the candidate is familiar with the passage or has memorized it. The learning of a few speeches will not require much time and provides the best way of demonstrating the candidate's acting ability. The try-outs should take place in a large room, preferably in an auditorium where the carrying power of the voice may be tested.

The Committee on casting should take careful notes on the work of each candidate, independent of each other, before the Committee vote is taken. The points to be noted are: (1) physical adaptability for the part—always remembering that make-up may do wonders with a mobile face, (2) voice: the ability to project, clearness of enunciation, range, etc., (3) general ability to get out of the natural self and into the character—an intelligent feeling for the part.

The last two requirements may be developed to a large extent in the rehearsals. But an actor must have a good carrying voice and an ear for variety in expression. Even in the try-outs the versatility or lack of it may readily be detected in the prospective players. A sophisticated city girl may play a part similar to her own real self, but she will never be able to play the rôle of a naïve country girl unless she has the ability to feel her part sufficiently to lose her identity in that of the character.

In selecting the cast for a High School play it is a good thing to try out different casts in selected scenes from the play studied. Thus an opportunity is given to a large number to participate. Those who perform best may be retained for the final production. Try to avoid the development of "type actors," in any case. Because an actor does a certain kind of part well, do not confine him to that particular type, but seek to round out his abilities and give him opportunity for expression in different parts.

## REHEARSING THE PLAY

With the cast selected, the first thing to do is to distribute the parts. Each member of the cast should receive a complete copy of the play, so that he may become familiar with the piece as a whole. For the full development of the individual players, especially in a study group, the entire play and the relation of each character to the whole should be carefully thought out by each actor for himself.

Before the first rehearsal the Director should be thoroughly familiar with the play. He should have the action tentatively blocked out in his own mind so that he may guide the players, until perhaps, by experiment, they work out more effective "business" for themselves in

the rehearsals. Any cuts necessary should be made before the players begin to memorize their parts. Changes in the text are always easiest at the first. Therefore the Director must be sure of himself; he must be master of the situation. He must not allow the players to argue with him. But on the other hand he must not impose his opinions in too arbitrary a way. Let him with tact win the confidence of his actors. Let them be convinced that he knows his business better than they do, that he has the advantage of perspective on the production as a whole, and all will be well.

The first rehearsal should be a reading rehearsal for blocking out the action. Each actor should write in his copy of the text all directions for "stage business"—that is, his movements on the stage, such as "crosses," picking up objects, sitting, etc. The prompter must keep an accurate record in the prompt-book of *all* such action, together with notes on interpretation, emphasis, etc. And if a player forgets to correct himself as directed, it is the prompter's duty to stop him and give him the directions previously worked out. An alert prompter will save much time and effort for the Director.

The Director must never allow a player to do the wrong thing. He must stop the entire play to drill on the interpretation of the lines or the business till it is established, and the other players should learn to help in these times when repetition seems monotonous.

The position of furniture must be clearly understood at the outset and the actual articles worked with as early as possible. If the cast cannot rehearse on the stage to be used for performance (and every effort should be made to hold all rehearsals there), the Director must select a room and indicate a floor space equal to that of the stage. On this, the entrances, exits, etc., should be clearly indicated. The players should never try to practice in a room which is too small or they will tend to huddle the action, and not give ample space for the stage picture.

The Director must have absolute control of the discipline in rehearsals. When a player is not on the stage he must be quiet. This does not mean that the rehearsals are to become irksome. Far from it—they will become more and more interesting—indeed they will become a fascinating experience with growing interest in the play and serious application to the work in hand.

Rehearsals must begin promptly and be regularly attended. Unless this rule is strictly enforced a director may spend more time at the telephone trying to assemble the players for rehearsals than is spent in actual preparations for the play. The actors must take their work seriously; they must realize the necessity for promptness and team work, and the selfishness of upsetting the whole cast for lack of such coöperation. This rule holds just as much for the minor parts as for the principals. If it is made a mark of honor to attain a place in the cast, and if others are retained as alternates when the

cast is selected, players will soon come to realize the necessity for strict attendance. The Director should not hesitate to replace a player who will not give up other engagements for rehearsals. Team work is one great lesson to be learned in dramatics, and it should be insisted upon from the first.

In planning the rehearsals the Director should endeavor to be reasonable in his schedule, not demanding more than the actors can reasonably be expected to give, and consulting the cast before posting his schedule. Rehearsals should occur daily if possible and not less than three times a week, with six full rehearsals the last week. A month or six weeks will usually be needed to prepare a play or group of plays in this way. Rehearsals should be long and intensive. In rehearsing a long play, the acts may be taken up separately, but they should all be rehearsed in proper sequence often enough for the actors to see the proper relation of the details to the action as a whole.

The actors must learn their lines very early in the period of rehearsing. No real acting can be done while the script is in hand. An actor should study lines at home, he should work alone to interpret the part, making additional business for himself where he can, and becoming himself master of the character.

## ACTING

Directing and acting are both largely affairs of the individual temperament. It is almost impossible to give any specific directions, however concise, in the short compass allowed here. There are no formal rules of acting. It is largely a matter of instinct and freedom of expression.

Of course the most important requirement is that the actor *feel* his part. Toward this end the Director must labor tactfully and ceaselessly, going into the psychological and emotional phases of the rôle, so that the actor may understand and feel just why it is natural for the character to speak and act as suggested. The Director should as little as possible show an actor *how* to do a thing, rather he should encourage him to work it out for himself, thereby creating instead of mimicking.

Certain suggestions, however, may not be out of place here although the individual requirements should always be kept uppermost in the mind of the Director.

The face is an expressive instrument, especially the eyes, and should be used to most advantage. Those on the stage should group themselves so that the chief speaker will be able to face "downstage," that is, toward the audience. The person speaking to another while both are entering should usually be the second to enter. In this way he may face front as he talks.

Since the actor's face is his most expressive agent he should let the audience see as much of it as possible. At the same time he

should remember that the face is a very important active and reactive instrument, hence, he should also allow his fellow actors to see as much of it as possible. This means that an important actor should not play long scenes with his face turned out of the audience's effective sight line, neither should he stand in the typical elocutionary pose with his face squarely to the front. The usual position allows the actor to keep three-quarters to the front so that the audience may see the changing expression of his face, yet permitting the other actors on the stage to look into his eyes and find there the reactions necessary for them. The actor should not be afraid, when the action demands it, to turn his face away from the audience for a short length of time. This is particularly necessary when a player down-stage must speak to another a little up-stage of him. When it is not advisable to place actors on the same line (such as in scenes involving three or more people) the Director should arrange his characters so that the person whose face at the moment is most important for the audience is in a position (presumably a little up-stage) where his face can be turned a little more toward the audience than the faces of the other actors.

No indecisive movements should be made. Move with decision or not at all. "Don't wiggle or wabble or creep," as one director has well put it. Always have a sufficient reason for making a "cross" or using a piece of "business" so that it will seem natural and not mechanical. Stage action must be clearly seen by the audience. To illustrate from Wilbur stout's *In Dixon's Kitchen**—when Annie Lee tosses Gil a pickle while seated behind the supper table, she must raise her hand high and let her throw be a decided movement. Otherwise the audience will not even understand what has been done. This rule may be reversed when something must be done on the stage unseen by the audience. For instance, a toad which is supposed to hop across the hearth may be moved to the required position by one of the actors if he will kick it gently with his foot while another character is attracting the attention to himself. A Director soon learns that actions which are not accentuated are not seen.

"Crosses" should usually be made on one's own speech, otherwise attention will be attracted by this movement away from the character speaking. Each player must remember that there is something greater than his own part—the play as a whole. Every movement, every change of position, every gesture, changes the stage picture. The Director must see that the players most vital to the action are in prominent positions if possible.

Each actor must act actively or silently all the time, never getting out of his part and remembering that pantomime is often more ef-

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* *Carolina Folk-Plays, Third Series. Henry Holt & Company, New York, 1928.*

fective than speech. Do not be afraid of pauses, *if* they are made to mean something. But the actors must seem to be unconscious of the audience—they must be absorbed at all times in the play.

The Director should insist upon proper enunciation. He should stand at the back of the room, from time to time, to see that the lines are clearly projected. He should not allow slovenly speech. Even in dialect pieces the lines may be pronounced with clearness and distinction. The words should be understood by the audience always and that, too, without straining the attention.

## THE FINAL PERFORMANCE

Two dress rehearsals should be held. At both rehearsals all furniture, props, costumes, light effects, etc., should be tried out, even if previously rehearsed. The scenes should be shifted, and the performance run through in all details. The first dress rehearsal is largely experimental. With even the most perfectly planned correlation of committees there will be certain props, pieces of furniture, details of costume, etc., which will need to be changed for the final rehearsal.

The head of each committee should make careful note of any changes at the first rehearsal and carry them out at the second. The lighting may have to be changed. Careful note must be made of all dimming, etc., and the cues for these changes followed, so that the sun will rise at the exact time expected and the lamplight will not shine forth in a room before the lamp is fully lighted.

The Director must be alert and ready to see that the different committees making up his machine function promptly and efficiently. When the walls are taken down by the shifters of scenery the Property Committee must be on hand to move furniture and small props into place in perfect time. All small articles, such as glasses of water, letters, etc., must be in their proper places on the stage or in the wings. Then, when the curtain goes up the play may go on without the nerve-wracking waits and desperate hunts for misplaced props.

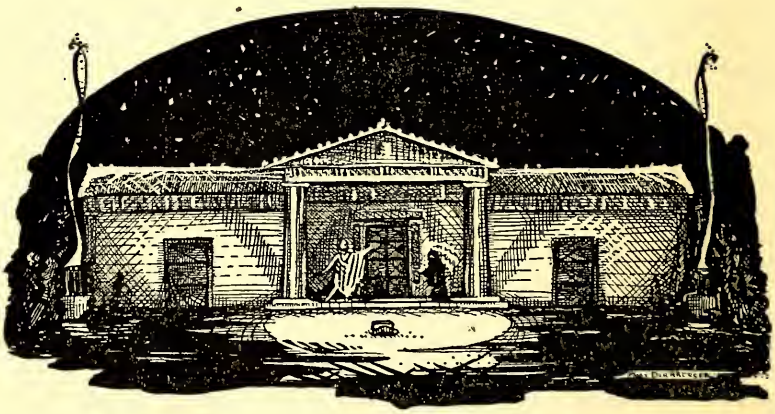
No visitors should be allowed behind scenes. The stage and the space behind should be kept clear while scenes are being changed and the number in the property and scenery organization should be limited on the nights of rehearsal and performance. This does not mean that others may not help in collecting properties, making costumes, etc. But there must be a carefully selected *few* behind scenes, especially if there is little space there.

The Director should have all actors at the theatre in plenty of time to dress and make up. The Make-up Committee should be ready with plenty of cold cream and cheese cloth and materials spread out conveniently. The Director should see that the actors come to be made up promptly, a few at a time, and not wait till the last moment to crowd in all at once for a hurried make-up. Talk and excitement should be discouraged among the actors. If the make-up room is kept quiet there will not be so much danger of "stage-fright."

On the night of the final performance there should be a special effort at promptness. The orchestra should begin playing in good time, and the curtain should rise promptly at the time advertised. Many audiences count on amateur delays, but the fact that the audience is not entirely seated should not delay the performance. Begin promptly always. Local audiences must be trained and, if the right start is made, they will soon know that the play will begin promptly. The ushers should request those entering late to remain at the back of the auditorium until the first act is over.

At the proper time, the member of the Scenery Committee assigned to the curtain should be ready. The prompter should be stationed just back of the curtain in the "tormentor" entrance, with a desk lamp so arranged that the light does not shine out into the auditorium. The workers operating all off-stage contrivances, such as wind machines, thunder sheet, etc., should be in place. The actors should be ready on the stage or at their entrances, and the Stage Electrician ready at the switchboard. Then the Director gives the signal, and the curtain is pulled. The play is on!

It is a good thing for the Director to go out and stand at the back of the auditorium so that he may be able to see and criticise the results of his work. This is the test of a perfect organization. If the Director is needed behind scenes for last minute details, the work has not been well organized. The Director should always keep his eye on the production as a *whole.* His function is to keep the right perspective, to harmonize all the various elements in the composite production of the play.



*The stage setting for Euripides'* "ALCESTIS." *A drawing by Mary Dirnberger.*

## PART III

# THE HIGH SCHOOL DRAMATIC CLUB

*By* John W. Parker

"The educational world at last understands to a certain extent that the first duty of every teacher is to interest his students, because we cannot learn unless we really care about the thing that is taught us. Whatever gave me pleasure in school and college has remained with me; whatever bored me, I have forgotten or could never bring myself to study alone at a later time. I believe that where there is no pleasure there is no learning," said Barrett Clark. Such opportunities of learning lie in the field of dramatics. It can no longer be an activity dictated by a director, but must be a study participated in or created by a student unit. In such a manner it can and will serve as a legitimate outlet for creative talent.

A Director who realizes the opportunities of creative dramatics will not be content to stage the "Senior Play," the "Faculty Play," and one or two other plays for remunerative purposes. Nor will he be satisfied to train only a few actors who will appear in all performances during the year. An alert instructor will desire *creation* rather than *exhibition.*

It is, nevertheless, a truth that there are too many dramatic advisers who are unaware of its possibilities. Too many schools, considering only the paltry sums to be spent in buying shades for rooms or books for the library, carry on dramatic activities in a slip-shod manner. The work is usually assigned to some teacher of English who is already weighted down. Hence the art suffers, and dramatics is not accorded the place in the program of studies which it deserves.

Such a condition demands a changed status. In the Senior High School of High Point, North Carolina, such a reorganization is producing desirable results. With a student body of approximately twelve hundred, there are two dramatic groups: The Junior Green Mask Dramatic Club, composed of members from the Freshman and Sophomore classes, and The Senior Green Mask Dramatic Club, whose members are selected from the Junior and Senior classes. Each group has a separate Director and two assistants, thus providing for a variety of interests through the departments of play-writing, lighting, scenic designing and construction, costuming, make-up, and acting. The placement of students is determined through their specifying on a mimeographed application blank their preferences. Then through try-outs or private conferences, the Director, with a committee of old members of the club, determines the fifty persons to be admitted. The blanks of all applicants are kept on file so that any vacancies can be properly filled. The application blank used is given below.

## APPLICATION FORM FOR DRAMATIC CLUB

Name.....

Home Room.....

City Address.....

Tel. No.....

Schedule

1st period.....

2d period.....

3rd period.....

4th period.....

5th period.....

6th period.....

7th period.....

Check the two departments in which you are most interested.

| | |
|---|---|
| Playwriting | Scenic designing |
| Assistant directing | Scenic construction |
| Acting | Lighting |
| Make-up | House management |
| Costuming | Advertising |

List in order of occurrence any phase of dramatic activity in which you have participated for the past three years.

The initial work of the club is that of a symbolic initiation ceremony, which features fantasy, comedy, tragedy, music, and the dance. The farcical idea entirely abandoned, the symbolic program is presented before the faculty, the new members, and parents of all club members. The ceremony is followed by a reception which, of course, promotes fellowship as well as appreciation of work begun.

Once initiated, the students begin departmental work, the departments meeting as often as interest or necessity demands. As might be expected, departments function more normally while a production is under preparation. The first group to begin work are the play readers, who suggest plays to the Director. With the play decided upon, the cast is then chosen through the processes of try-outs, charades, and a study of the individual when he is not conscious of being observed. Through the playing of charades, planned for in advance, talent is often discovered; for at play the would-be-actor

is more normal than if he were reading a given passage. Then through try-outs and observation, diction, empathy, and ability to read and to interpret lines can be determined.

As rehearsals get under way, other departments begin functioning. The crew in scenic designing begins a study of the play in order that it may be staged against a fitting background. They endeavor to create scenes that require an understanding of line, color and symmetry. They are often guided in their selection of color and arrangement through a study of pictures and actual rooms. Stage models and drawings constructed to scale are submitted to the Director, who in conjunction with the stage crew, selects a model or models. Work on the set then begins.

By this time the crew in scenic construction has busied itself in determining what supplies must be placed in stock for the building of the set. A committee, having been advised by the Director, makes a shopping tour and purchases material to be used in the workshop. As no time is provided during school hours for the actual building of scenery, the stage crew finds it necessary to work after school, at night, and on Saturdays. To reward them for extra-curricular work, after the completion of twenty hours work, each new member of the crew is awarded a pair of green union-alls with the club signet stenciled on the back.

Those interested in costuming are also at work by this time. They seek information from authentic books on costumes. Often one produces miniature models by the dressing of dolls. Then under the guidance of the Director, or an interested mother who knows costuming and sewing, the actual making of costuming begins.

Another service rendered by this group is the care of the costume room. As the costumes are club property, they are listed in a book by number and charged out to the individuals using them. Garments, furthermore, are protected by coverings made by this group. The renovation of garments reduces expenses. A scrap-book, containing period and type pictures together with brief descriptions, also proves invaluable.

The group studying make-up finds it necessary to have in mind a distinct picture of each character so that he can be accurately portrayed. The activity of these pupils is, therefore, not limited to the nights of dress rehearsal. Under guidance, they experiment frequently on one another. Along with experimentation, they study various books on the art of make-up and practice given suggestions. The work of the group is rewarded with green smocks which bear the club signet. Such awards motivate and sustain interest.

As the production nears completion, those interested in business management and advertising begin intensifying their work. The mediums of placing the show before the public are determined and the "out-front" organization is perfected.

Cooperation between departments is promoted through club meetings, held every two weeks. These meetings are planned so as to bring about a maximum amount of interest and enjoyment and to promote speech culture and interpretation. The programs provide drills in diction, pronunciation, enunciation, and projection. A study of pantomime and interpretation of character is also emphasized. The scope of club work, furthermore, includes the bringing in of interested patrons who discuss current productions, modern plays, and other dramatic literature. Work done by club members in assisting other organizations in putting on their productions fosters cooperative interest in school activities. Through affiliation with the Carolina Dramatic Association and through conference and correspondence, the club keeps in touch with other dramatic organizations in the state. A competition with other amateur groups in state contests also heightens interest.

As it must be a self-supporting organization, it puts on during the year two programs in the auditorium, admission to which is gained through the payment of a nominal sum. That the organization may be known publicly, two major productions are also staged.

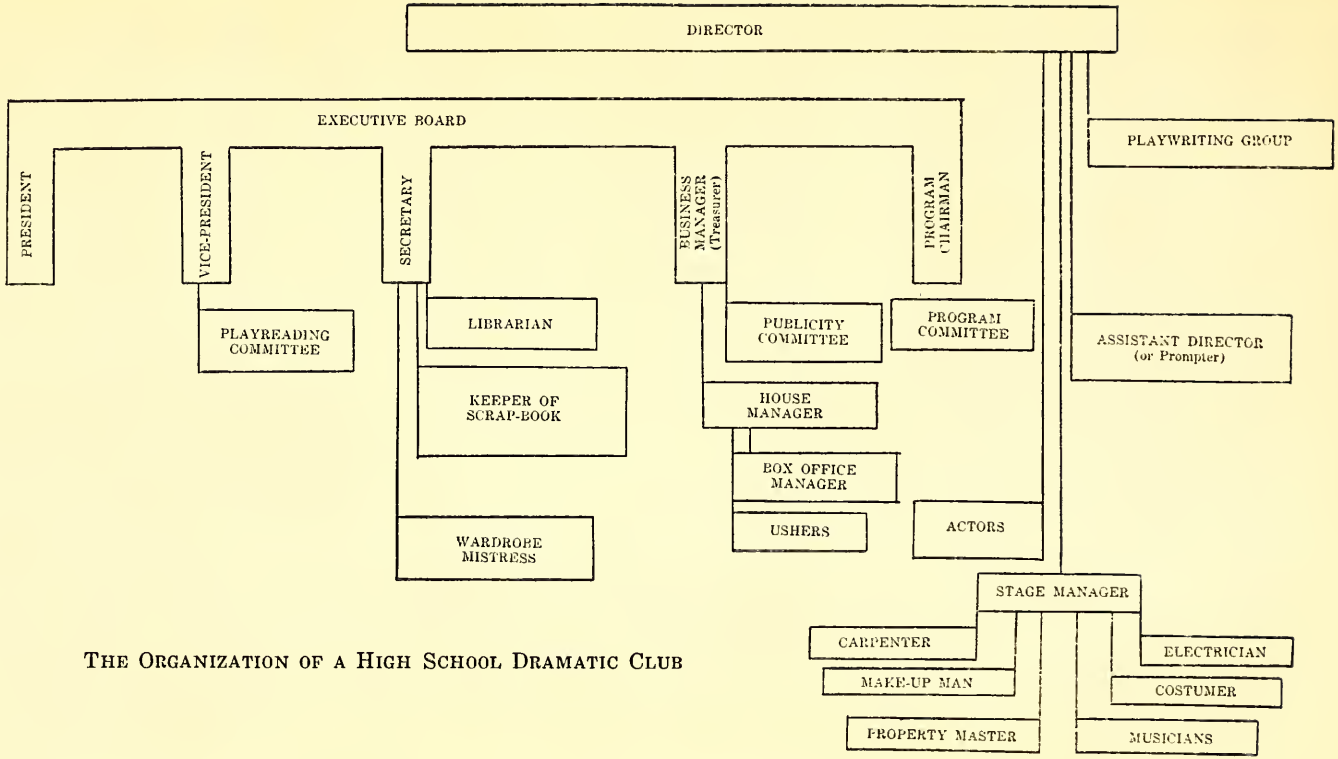
With such interests, noticeable results are obtained. Among the students there is a wider reading of plays, a development of poise and leadership, and a promotion of citizenship among those who probably would not acquire such through class-room procedure.

The plan of organization of The Senior Green Mask Dramatic Club of High Point High School, Miss Meek Beard, director, is diagramed on the opposite page, and may well serve as a model for any high school group.

## EXPLANATION OF THE DIAGRAM

MEMBERSHIP: In a school of average size one dramatic club in usually sufficient to take care of the needs and interests of the students. In larger schools, however, it may be advisable to divide the group, according to ages or classes, with a separate director in charge of each group. In determining the membership list, provision should be made not only for those interested in acting, but also for those interested in the other phases of dramatic art and play production, such as: playwriting, scenic designing and construction, costuming, make-up, business management, etc. The Director and Executive Board should decide upon the admission of new members and a membership fee may or may not be charged.

DIRECTOR: The Director should confer with the Principal of the school concerning policies to be adopted by the club. He should be *ex officio* member of all club committees and the final court of appeal in all differences which may arise. He should supervise the selection of plays to be produced and select the cast through a process of try-outs. He should have charge of all rehearsals and direct the activities of the stagecraft department.




THE ORGANIZATION OF A HIGH SCHOOL DRAMATIC CLUB

EXECUTIVE BOARD: These officers should be elected by the club members to serve in their respective capacities for the period of one year.

A. PRESIDENT: He should preside at all club meetings and, with the approval of the Director and Board, appoint all committees.

B. VICE-PRESIDENT: In the absence of the President, he should assume his duties. He may also be chairman of the Play Reading Committee.

(a) *Play Reading Committee:* It is the duty of this committee to read as many plays as possible and to recommend to the Board plays to be considered for production.

C. SECRETARY: He should write official communications, keep files of letters, record the minutes, etc. He should supervise the activities of the following:

(a) *Librarian:* He should catalogue and file all plays which are the property of the club.

(b) *Keeper of the Scrap-book:* He should collect and arrange copies of programs, reports of performances, newspaper clippings and pictures of performances. Separate scrap-books may be kept for designs of settings, costumes, etc.

(c) *Wardrobe Mistress:* She should catalogue each garment and property owned by the club and charge out each article to the member using it. The care of the property and wardrobe room is under the supervision of this person.

D. BUSINESS MANAGER (Treasurer): He should control the funds of the organization and supervise the following committees:

(a) *Publicity Committee:* They should map out and execute the plans for advertising each production. They should also arrange for tickets, programs, posters, and handbills.

(b) *House Manager:* He should be in charge of the "out-front" organization, including the box office manager and ushers.

E. PROGRAM CHAIRMAN: He should supervise and head the Program Committee.

(a) *Program Committee:* They should plan for all general club meetings so that the maximum amount of enjoyment and training may be derived.

PLAYWRITING GROUP: The Director should encourage and direct all members who are interested in writing plays. Provision should be made for experimental and public performance if the plays warrant.

ACTORS: All club members who are interested in becoming members of a cast should be given the opportunity to do so through a process of try-outs, conferences, etc. They are under the supervision of the Director.

PROMPTER (Assistant Director): It is the duty of this person to

meet all rehearsals, prompt the actors and assume the duties of the Director in his absence.

THE STAGE CREW: So as not to limit the number of this group, anyone who is interested in designing, building or painting scenery should be encouraged to participate in the workshop activities. For scenery rehearsals and the actual performance of a play, the Director may select those who are most competent to act as the stage crew. The members of this crew may vary from one performance o another.

(a) *Stage Manager:* He should supervise the stage crew in "setting" and "striking" the scenery. If authorized by the Director, he should direct all "back-stage" activities during the time of a performance.

(b) *Carpenter* (and Assistants): They should take charge of "setting" and "striking" flats, drops, borders, ground rows, etc.

(c) *Electrician:* He should operate all electrical devices.

(d) *Property Master:* He should have charge of all furniture and hand properties.

(e) *Costumer:* He should see that all actors are in their proper costumes for each act.

(f) *Make-up Manager:* He should assist the actors with their make-up.

(g) *Musicians:* They should furnish the incidental music and the music between the acts.

## PART IV

# DRAMATICS IN THE SMALL TOWN

*By* Frederick H. Koch

The foregoing plan of organization may be altered and simplified to fit the small town. The High School will furnish much ready-made machinery for developing the work of a dramatic society to fit its own particular needs and in correlating its activities with the school curriculum.

In the first place it will be easy to impress the students with the serious aim of the work if it can be made an essential part of class work in various departments. The dramatic classics studied in language courses may be vivified by actual representation on the stage. Other pieces of literature lend themselvs to dramatization. Simple original plays may be written as part of the composition work in English, and produced with surprising enthusiasm and success. The Domestic Arts classes may design and execute costumes. The Manual Training department may construct the frames for the scenery, and design and make furniture and various mechanical devices such as the wind machine, thunder sheet, etc. There will be found in every school some boy interested in electricity who will be eager to try his skill in stage lighting. Here is a unique opportunity of great educative value—the application of the results of classroom designing and experimentation in a concrete and vital art.

A properly qualified teacher should act as Director of the High School Dramatic Society. Several teachers may share the responsibility of the different programs. But it is best, perhaps, if that be possible, to have a single Director at the head of the organization. The Director of such a group need not necessarily be a teacher of English. The prime requisite in work with young people is the quality of leadership. The Director must be a "good fellow," one to whom the students will be loyal, one who will control without seeming to stand apart from them as disciplinarian. Sympathy and patience and youthfulness of spirit in the Director presage his success.

In the School Club plan, now growing in popularity, dramatic work has an important place. Each student is allowed to join one of the several clubs which devote one meeting a week to such fields as Nature Study, Boy Scout and Camp Fire Work, Music, Drawing, etc. Those who join the Dramatic Club devote their time to the study of worthy plays and to the details of stage performance of selected plays. In many cases other clubs cooperate with the Dramatic Club in the actual production of plays. Such a High School Club or any Woman's Club group which plans to study as well as produce, may find it advisable to charge membership fees. In this way the membership may be limited to those who are serious and willing to work.

The Dramatic Club of one of our small North Carolina towns has done such excellent work that a discussion of its work may be of

value here. The teacher of history in the High School organized the group. Through her own interest in the history and traditions of that section, she aroused an appreciation of local legends and incidents as dramatic materials. With the study of scenes and short and long plays the club has paid special attention to the dramatic form with a view to original composition. Some simple but exceedingly interesting plays were written during the first year of such organized work.

The Lincolnton High School Dramatic Club meets every Friday afternoon, in two sections of one hour each. On the third Friday in each month the first section presents informally at a joint meeting a scene or one-act play which has been prepared in the two previous section meetings. On the fourth Friday the second section presents the program. At these joint meetings problems are discussed, and brief talks given on problems of acting, stagecraft, etc.

*The Taming of the Shrew* was so excellently done that demands came from many neighboring towns for its presentation. The players entered into the spirit of the comedy and learned, all unknowingly, the true dramatic worth of the master, Shakespeare. If merely the classroom knowldge of the play had been learned, what a wealth of vivid impression, free imagination, and training in the art of the spoken word and action would have been lost to the youthful player forever!

As their commencement program, The Dramatic Club seniors presented three one-act plays, chosen from those which they had read and presented informally—*Suppressed Desires*, by Cooke and Glaspell; *Neighbors*, by Zona Gale; and *In Dixon's Kitchen*, one of the Carolina Folk-Plays, by Wilbur Stout, of The Carolina Playmakers. These three comedies gave an excellent opportunity for character acting. Seventeen different players were given parts, and the work was not difficult for any individual, as all the plays were short.

The producing organization for these plays was very simple. It consisted of Make-up, Property, and Stage Construction Committees which enlisted the aid of teachers in various departments. A talented High School boy acted as Director of Lighting and the music and business management were all provided by the school group. Some old stage scenery of hideous design was repainted with Calcimo in a soft neutral tan, and suitable doors and windows were constructed. The director wrote of the ease with which they accomplished the program of one-act plays, "I am so proud of them, for they did every bit of the work without a bit of help from anyone except a hint or two from the superintendent. One of the boys made a new set of footlights and placed them. Three of the boys were responsible for shifting the furniture and setting the stage, one for each play. The superintendent said that there was so little confusion that he doubted whether a play was being presented or not." The fine cooperation of teachers and pupils was responsible for this success.

The achievement of the Lincolnton High School has been duplicated in many another North Carolina town. There is no community which cannot provide the simple equipment necessary for such a dramatic organization in the school.

*The stage setting for Euripides' "*IPHIGENIA,*" by John Walker. A drawing by Lena Alice Tuttle*

Two simple interiors. The setting for Joseph Fox's *Hollyhocks* by Elmer Hall, and the setting for Loretto Bailey's *Cloey* by Samuel Selden. Original plays written in the University Playwriting Course and produced by The Carolina Playmakers.

Two scenes from The Playmakers' recent première of Paul Green's *The Enchanted Maze*, directed by Samuel Selden. The scenery by Samuel Selden and Wilbur Dorsett, and the lighting by John Walker. Above: the Campus. Below: the Commencement.

PART V

# LITTLE THEATRE ORGANIZATION AND MANAGEMENT

*By* JOHN W. PARKER

## MEMBERSHIP

The membership of a dramatic group should be comparatively large —much larger than it usually is. It should be always kept in mind that dramatics is a democratic art; therefore the list of members should not be limited to actors only, but should include those who manifest an interest in any of the various theatre arts, whether it be costume designing, carpentry, lighting, stage management, advertising, or make-up.

In a community organization there are usually two types of members: *active* and *subscribing*. The active members are those who actually carry on the business of play production, while the subscribing members are those who are seriously enough interested in the advancement of a local dramatic group to pledge it not only their good will, but their financial support. Both types of members purchase a season ticket at the beginning of each season, and it is they who form the nucleus of the audience.

## BUDGET

Unless the organization is subsidized by a wealthy patron, or patrons, it must largely depend upon the box office receipts for its support. For this reason the advance season ticket sale is of prime importance. At the beginning of each year, the group should decide how many public productions it shall present during the season, what the productions shall be, and the price of single admission tickets. Season tickets should admit the holders to all of the public productions, and should be so sufficiently reduced in price as to appeal to the average theatre-goer.

Thomas B. Humble, director of The Little Theatre of Charlotte, North Carolina, writes: "The Little Theatre of Charlotte works on a membership basis. There are six plays given each year, and a membership fee of five dollars ($5.00) entitles the holder to one seat at each production, as well as to one seat at the workshop productions (one-act plays), presented six times each season.

"When the membership is closed, our income is budgeted for the six major productions, and from that we work. As the year advances we rebudget when necessary, and so far we have been able to keep our heads well above water. The Little Theatre of Charlotte has been running for eight years now, and there has not been a season that we have ended 'in the red.'

"Each season we give an extra cash play, not included on the season ticket, and on this production we always figure on clearing five hundred dollars ($500.00).

"We have only one paid member on the staff—the director. He works on a salary and a percentage basis. At times it is most satisfactory, and certainly makes a director do his best for perfection in productions."

T. Bryan Tate, secretary of The Little Theatre of Danville, Virginia, states: "Our Little Theatre puts on a membership campaign in the early fall, preferably after our local boarding schools are open. All old members who will cooperate canvass the city. In the past we have only charged one dollar and twenty-five cents ($1.25) per membership. This sum is really too small, and we expect to raise this fee to two dollars ($2.00) next fall.

"After our membership campaign, we make out a budget for the season. The first item is for the sum of one hundred dollars ($100), set aside for our building fund, and to be touched under no condition except toward a building of our own.

"We give three major productions (three full-length plays) and several productions of one-act plays during the season. Our budget is made to cover only the major productions." The Little Theatre of Danville does not have a paid director.

In commenting on the problems of their budget, Waldeen H. White, director of The Twin-Village Players of Jamestown and Sedgefield, North Carolina, said: "Our membership dues are only fifty cents (.50). The membership list numbers around thirty (30) and there is as yet no supporting membership other than this. Our program calls for two public productions, one in the fall, the other in the late spring, and a bill of one-act plays to be presented before club members only. We are a little more than a year old. The fall production has safely financed our winter activities and has provided us with a set of screens and several much-used properties. I think we have been lucky in our purchasing, since everything seems to be coming in handy again and again. Plays are given in the school auditorium, where there is no rent, and our spring production, we hope, will find us with a little cash on hand."

The Business Department requires skillful management and systematic planning. A careful manager will know what the probable income will be, and he will figure a sufficient margin so that if his income is not what he expects it will be, he will nevertheless clear expenses. Items which will probably appear on his budget will be expenses covering the rental of a theatre, the construction of scenery and costumes, make-up, the printing of tickets and programs, royalty, and advertising.

After each performance the Business Manager should permanently record a complete report, showing the actual expenses, and the profit or loss, as the case may be. This record should prove very valuable to future Business Managers who will profit by past experience.

## TICKETS

It is a duty of a Business Manager, or an assistant, to see that tickets are printed and that they contain all the necessary information: the time, date, place of performance, and the price. It is more satisfactory to number the seats, so that persons may know in advance just where they are to sit, than to sell admission only. This means that tickets must be numbered to correspond with the numbers on the seats. A floor chart or model of the auditorium enables the Ticket Manager to check off seats as they are sold and to see at a glance where the unsold seats are located. Where there is no single box office to which purchasers come and when tickets are sold by various people throughout a community or school, advance tickets, unnumbered as to seat, may be exchanged at the box office prior to the performance at certain specified hours. The Business Manager should arrange for the selling of tickets and for their collection at the entrance to the theatre.

## PROGRAMS

Just as scenery and costumes assist in portraying the mood of the play, so does an effectively designed program. Whether it be an interesting little magazine containing a discussion of the play, suggestions about the future plans of the group or other information of interest to the audience, or whether it be a single sheet containing nothing but the cast of the play for the evening, the program needs artistic planning.

Each organization should adopt some standard form to use in all its programs, rather than to leave the form to the caprice of each manager or a printer. The use of a signet or woodcut apposite to the group lends a certain dignity and feeling of antiquity which should be cherished by non-professionals.

Although the heading and general form of a program may be the same for all productions, various effects may be secured by changing the colors of the ink and paper and by appropriate selection of borders.

## ADVERTISING

The Advertising Committee is the connecting link between the theatre group and the public. It must keep in mind the aims of the group and must create an attitude on the part of the public in keeping with these aims. Free advertising is the best advertising. Favorable comment, word-of-mouth praise, is far more efficient as a medium of advertising than any other device, no matter how gaudy or expensive. Therefore, the "whispering campaign" is an effective way of making the general public conscious of what is being done by a dramatic organization.

The daily newspaper offers itself as an excellent medium for plac-

ing the show before the public. Beginning several weeks before the actual presentation of a play, those in charge of advertising should see that opportune feature stories and news stories frequently appear. A breezily written article on some of the difficulties encountered in staging a production or a discussion of the circumstances under which the play was written is more likely to attract attention than a dull headline. In a news story, mention should be made of the "who, what, where, when, and why," the stars of the production, the features of the play, the author, and where the tickets may be obtained.

Often the same posters as those used in the original Broadway production may be obtained at a nominal price through the owners of the copyright, and billboard space for a few days may be donated or obtained for practically nothing. Well designed, hand-made posters always attract attention and make a good showing. Interest may be further aroused by a poster contest, with a season ticket as the prize. A model, or series of models, of the stage settings to be used may be exhibited in a store window. Sometimes, too, it is possible to show scenes from the play as part of an assembly or chapel exercise.

The ingenuity of the Publicity Committee finds a challenge in discovering unique and dramatic mediums of advertising—of making the community drama conscious—of instigating the desired "whispering campaign."

## CONTROLLING THE AUDIENCE

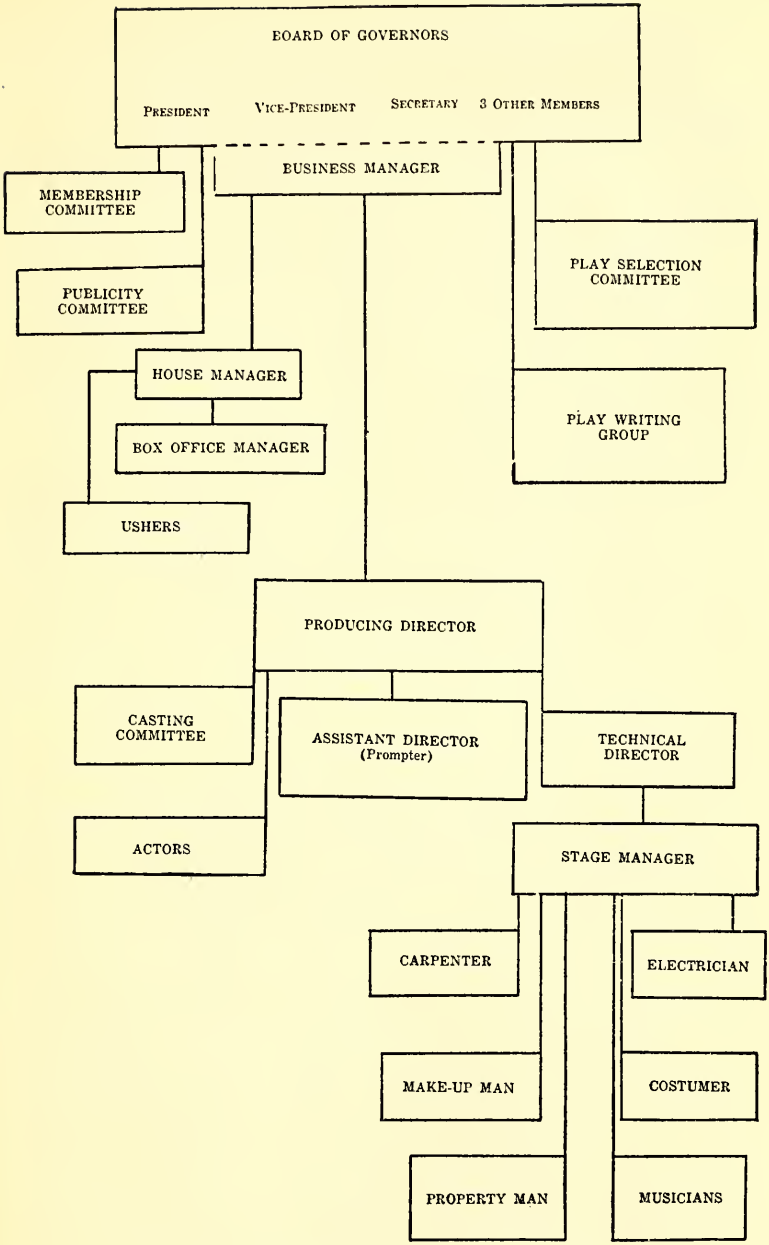
The House Manager acts as host for the theatre group. Each member of the audience is his guest, and he must see to it that they are received courteously by his staff of ushers. The ushers should be thoroughly acquainted with the seating arrangement of the auditorium, and thus be able to show each person to his seat with as little confusion as possible. A competent "out-front" organization is large enough to take care of the business of collecting tickets, distributing programs, and seating the spectators. It is a duty of the House Manager to see that the theatre remains at a constant and comfortable temperature, and that it is properly ventilated. He must be able to calm the audience in case of accident or fire and at all times control his temper in any emergency which may arise at theatrical performances.

## EXPLANATION OF THE DIAGRAM

MEMBERSHIP: A Community Theatre group should be composed of as large a membership as possible. General membership may be divided into two classes:

A. ACTIVE MEMBERS: Those who actually take part in some phase of play production activity.

B. SUBSCRIBING MEMBERS: Those who buy a season ticket that they




THE ORGANIZATION OF A LITTLE THEATRE

may promote the activities of the group and that they may see all of the productions.

Note: Both active and subscribing members should purchase a season ticket.

BOARD OF GOVERNORS: The following officers should be selected from and elected by the general membership group to serve in their respective capacities for the period of one year. They should decide all policies to be adopted by the group.

A. PRESIDENT: He should preside at all general meetings and appoint all committees.

B. VICE-PRESIDENT: In the absence of the President, he should assume his duties.

C. SECRETARY: He should write official communications, keep files of letters, record the minutes, etc.

D. THREE OTHER MEMBERS: These may be persons competent to head and direct the following committees:

(a) *Membership Committee:* It is the duty of this committee to promote an intensive campaign at the beginning of each season for the purpose of bringing new talent into the group and to increase the subscribing membership list.

(b) *Play Selection Committee:* It is the duty of this committee to read as many plays as possible and to recommend to the Board plays practicable for production.

(c) *Playwriting Group:* Provision should be made to produce experimentally all plays written by this group, and if the plays warrant, public productions should be given.

E. BUSINESS MANAGER (Treasurer): He should control all the funds of the organization. Having been authorized by the Board concerning the amount of money to be spent on a single production, he should become *acting head* of that production, dispensing money to the Publicity Committee, Producing Director, the Technical Department, etc. He should arrange for the printing of tickets, programs, posters and handbills. Responsible to him are:

A. THE PUBLICITY COMMITTEE: This Committee should map out and execute plans for putting the show before the public.

B. THE PRODUCING DIRECTOR: Since the Producing Director may change with each production, it is wise to have him responsible to the Business Manager where money matters and general policies are concerned. This prevents a general reorganization at the close of each production. The Producing Director may or may not be paid for his services, depending upon the financial backing of the organization. He should select the cast through a process of try-outs, take charge of all rehearsals and supervise the Stage Craft Department. If a paid Director is permanently employed, he,

of course, should be a member of the Board of Governors. Responsible to him are:

(a) *The Casting Committee:* This Committee should assist the Producing Director in casting the play. His word, however, should be final in the selection of the members of the cast.

(b) *The Actors:* All active members should be given the opportunity of trying out for a part in the play. The cast having been selected, all actors are under the direct supervision of the Producing Director.

(c) *The Assistant Director* (Prompter): He should attend all rehearsals, prompt the actors and assume the duties of the Producing Director in his absence.

(d) *The Technical Director:* Wherever possible a person who has a knowledge of designing scenery and costumes and the ability to direct workshop activities, should relieve the Producing Director of the job of actually constructing the scenery. In the workshop all active members of the organization should be given the opportunity to design, construct and paint the scenery, work out the light plot and, in general, take care of the technical part of the production. For scenery rehearsals and the actual production of the play, the Technical Director may select those who are most competent to act as the stage crew.

(e) *The Stage Crew:*

1. *Stage Manager:* He should supervise the stage crew in "setting" and "striking" the scenery. He should be responsible for all "back-stage" activities during the time of a performance.
2. *Carpenter* (and Assistants): He should take charge of "setting" and "striking" flats, drops, borders, ground rows, etc.
3. *Electrician:* He should operate all electrical devices.
4. *Property Master:* He should have charge of all furniture and hand properties.
5. *Costumer:* He should see that all actors are in their proper costumes for each act.
6. *Make-up Manager:* He should assist the actors with their make-up.
7. *Musicians:* ...They should furnish the incidental music and the music between the acts.

PART VI

# THE CONSTRUCTION AND PAINTING OF SCENERY

*By* SAMUEL SELDEN

## 1. THE PURPOSE OF SCENERY

The whole art of the stage is the art of Presence. Presence in the theatre is the enkindling influence exerted by a personality of superior radiance. The personality may be that of a man or a woman, or it may belong to an inanimate object which, because of its association with human action, takes on a living quality. A rug, a wall, a chair, a dress, or a snatch of song may have a "presence."

The supreme stage presence is, of course, the actor's. Because he is the most direct and intimate embodiment of the playwright's vision, his radiant influence dominates all the others. In fact, in many periods of theatre history the actor has had to assume, not only the chief part, but all the responsibility in creating dramatic presence. The early Greek players performed the dramas of Aeschylus, Sophocles and Euripides before a simple stone façade. The actors of Shakespeare's time used an open wooden structure with a minimum of stage properties. Molière often played his comedies on the barest type of platform with the help of no other scenic aids than a plain table and a pair of ordinary chairs. Yet he and his fellow actors were able by their words and movements to establish the atmosphere, or presence, not only of the characters they portrayed, but also of their surroundings.

Since Molière's time other artists have contributed to the effects of a stage performance. This is particularly true of the scenic artists. Sometimes, over-earnest to create surrounding forms which should exert upon the audience the influence of their own pictorial personality, they have nearly destroyed the influence of the actor. Only in comparatively recent times has much thought been given to the efficient blending of the two arts. The guiding influence of the so-called "new stagecraft" became clearly defined only around the turn of the present century. In accordance with them, the actor's presence remains—or becomes again—the center of the dramatic design, but the "presences" of the scenic forms (walls, furniture, and lights) which surround him become increasingly important in the creation of a right mood for the player's actions, supporting the force of his influence on the audience.

Modern dramatists, striving for greater economy by omitting from their plays the long passages of description and exposition which slowed the action of older plays, are leaning more and more on the effects produced by stage settings to describe their characters and to advance their stories. The significance they attach to the scenic environment of the dramatic action is indicated by the careful specifications they place in their stage directions.

Loretto Carroll Bailey begins her one-act play of frustrated desire, *Cloey*, in this way:

*When the curtain rises,* JOSEPH HALL *is sitting at a little walnut desk in* MRS. MOTSINGER'S *living room, busily chewing a pencil, and writing at intervals.* JOSEPH *is a rather good-looking man of thirty-five, pleasing—often appealing—but somewhat ineffectual. He fits rather nicely in the dim sitting room on the edge of "Germantown." It is a quaint, musty little room, with a great fireplace in the middle of the back wall, and shallow alcoves on either side of it. The light filters through small diamond-paned windows at the back of the alcoves, falling on dim and dusty books in the shelves, bringing faint color to the portrait above the fireplace—the portrait of a girl with a pretty, spirited face. . . .*

A full appreciation of the story of Joseph's ineffectual hope to better himself, Cloey's wistful longing for release and Mrs. Motsinger's peculiar ordering of their lives would be impossible without that musty, dimly-lighted little room. Before the play is over nearly every object visible takes some part in the action—the table in the center, the high-backed chair by the fireplace, the curtains on the alcoved windows, the silver candlesticks on the mantelpiece, and, above all the others, the portrait of Cloey's mother on the wall. *Cloey* is a play of presences.

The modern stage setting describes character and creates mood for action. It also helps the player tell a story. If we should attempt to give an informal definition of scenery from the point of view of a modern designer in the theatre, we should say, perhaps, that it is the living *environment* of the actor. The able artist enters into close communion with the author and the director of a projected play, and then, with the design of the acting clearly in mind, conceives for it surrounding forms which will explain its meaning and intensify its effects. The walls, the doorways, the rugs, the tables, the chairs, and—above all things—the lighting which he plans, will not be simply architecture, furniture and illumination; but objects and qualities possessing an animate, vibrant presence, exerting an influence which, blended with the acting, makes the audience understand and enjoy the play to the highest possible extent.

## 2. SOME GENERAL CONSTRUCTION HINTS

A stage setting should be designed primarily for ease and rapidity of set-ups and removals. The interest of the audience must be held and intensified as the play goes on, and this can be done only by having the time required for shifting reduced to a minimum. While durable enough to stand continuous handling, scenery should be planned to be light and portable. It is made light by constructing, wherever possible, the larger pieces of canvas stretched on wooden frames instead of solid lumber, and portable by building each set in small unit parts which can be quickly assembled and taken apart.

The methods of putting together the various pieces must be contrived in such a way as to make it unnecessary to drive a nail during the performance. Nothing sounds more "amateurish" to the audience than hammering from the stage. A little scheming will make it possible to fasten the larger units by the use of lash lines and lash cleats, and the smaller ones by the use of loose-pin hinges, so that they may be handled quickly and silently at all times.

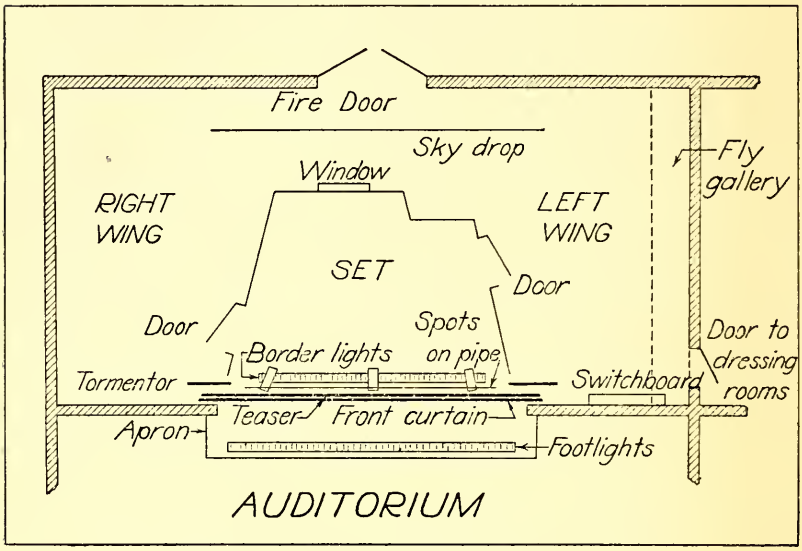



FIGURE 1: FLOOR PLAN OF A TYPICAL STAGE

*Showing the positions of the proscenium opening, the front curtain, teaser, tormentors, footlights, border lights, spotlights, switchboard, fly gallery, door to hallway leading to dressing rooms, and an interior set in place. The fire door, or "loading door," for carrying scenery in and out, is more often located at the side of the stage than at the back. A smaller outside door, the "stage entrance," used by the actors and crew, is not shown in the diagram. It opens from the street into the hallway at the right.*

White pine strips (3 in. x ⅞ in.) and muslin are the two most useful materials for constructing on the stage. Elaborate morticed and tenoned or mitred joints are unnecessary. A simple square (butt) joint held with a couple of corrugated fasteners and reinforced with a small triangle or rectangle of ¼ in. three-ply board is both strong and rapidly made.

In the few pages following it is impossible to take up more than briefly the most common problems of building. A good stage designer should be unafraid to use his ingenuity. Each new play presents its own questions, many of which can be answered only by the man actually working on it.

## 3. MATERIALS REQUIRED FOR A SMALL BOX SET*

For building a simple interior set of seven flats, each measuring 12 ft. high and 5 ft. 9 in. wide with two doorways and a window opening, the following materials will be required. Special lumber and hardware needed for accessory pieces discussed in a later section are not listed here.

*Lumber.* White pine, clear of knots and dressed (planed) in strips 12 ft. or 18 ft. long in two widths, 3 in. x ⅞ in. and 2 in. x ⅞ in., is the most useful wood out of which to construct the frames. It is light, soft, tough, and easy to handle. Where it is impossible to secure white pine, any other soft wood such as yellow pine or fir may be substituted. In surfacing the lumber at the yard the 3 in. strips are often dressed down to about 2¾ in. and the 2 in. strips to about 1¾ in. This should be taken into account in measurements during construction. In ordering, estimate 30 lengths of the wider strips and 3 lengths of the narrower strips cut 12 ft. 0 in. long. This allows a little spare to take care of possible warped or split ends.

Also, order enough cheap ¼ in. three-ply board to make 3 dozen triangles (corner blocks) about 8 in. x 8 in., and 4 dozen rectangles (keystones) about 6 in. x 3 in., to be used for reinforcing joints. Most carpenter shops have scraps of this veneer board lying around and will cut it up at very small cost.

*Muslin.* To cover the frames 30 yards of 72 in. width, or 60 yards of 36 in. width, cheap unbleached muslin will be required. The 36 in. width is generally cheaper for its width than the wider.

*Hardware.* Special hardware for lashing and bracing, which should include the following, may be ordered from any theatrical firm.

28 Lash cleats.
7 Lash line eyes.
6 Brace cleats.

It will be difficult to find any common hardware that will satisfactorily take the place of these, but 6-penny nails and screw eyes are possible substitutes. It will also be necessary to buy the following in a local store.

2 lbs. 1¼ in. lath nails.
8 boxes No. 6. carpet tacks.
1 box ¾ in. No. 5. corrugated fasteners.
1 box ⅞ in. No. 9 wood screws.
90 feet of sash cord.
2 lbs. ground glue.
2 lbs. whiting.

## 4. THE CONSTRUCTION OF THE PLAIN FLAT

A flat may be any height but its width is usually a standard 5 ft. 9 in. This width is more satisfactory than a full 6 ft. one in that it

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**A list of theatrical supply houses will be found at the end of the bulletin.*

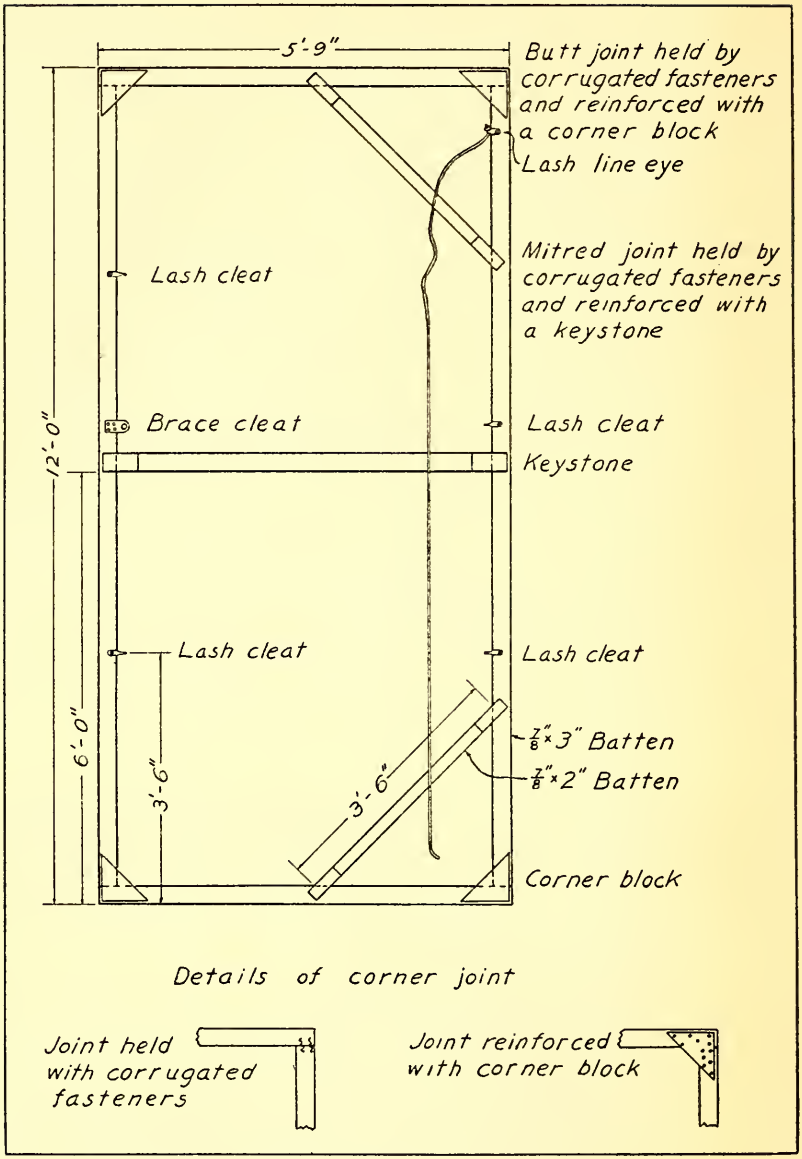



FIGURE 2: COUSTRUCTION OF A FLAT

allows, in covering, a 3 in. margin in the muslin to accommodate uneven stretching. There are other advantages.

The frame is built first. For a flat 12 ft. 0 in. high, cut out of 3 in. x ⅞ in. lumber strips two battens 11 ft. 6 in. long and two 5 ft. 9 in. long. Laying them on the floor or a work bench, put them together in the form of a rectangle with the top and bottom strips lapping the side strips as illustrated in the diagram.

Making sure that the corners are absolutely square, first secure each joint by driving a couple of corrugated fasteners edgewise across the seam and then reinforce it with a corner block and 1¼ in. lath nails. As the combined thickness of the ⅞ in. batten and the ¼ in. block through which the nails are driven is 1⅛ in., the extra ⅛ in. sticking through must be turned by holding a flat, heavy piece of iron against the wood underneath when driving. This makes a very firm joint.

Cut one straight piece of 3 in. x ⅞ in. lumber 5 ft. 3 in. long and two mitred pieces of the 2 in x ⅞in. wood 3 ft. 6 in. long to brace the center and the upper and lower right-hand corners. Secure as above with corrugated fasteners but reinforce with keystones instead of corner-blocks. A little neater job is done if all veneer parts are set in ½ in. from the edge.

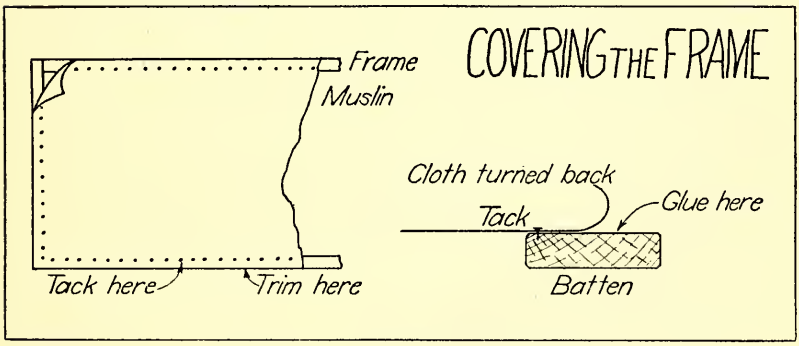



FIGURE 3: COVERING THE FRAME

Turn the frame over on its back. It is now ready for covering. If using the 36 in. width of muslin, seam together strongly two strips to make a piece about 6 ft. x 12 ft. 4 in. A little of the muslin will be lost in the sewing but this does not matter. Lay this with the seam downwards on the frame so that an inch or two of cloth extends over the edge of the frame all around. Stretch the cloth and fasten it in position with four temporary No. 6 carpet tacks driven in part way only in the four corners.

Now tack the muslin to the wood a quarter of an inch from the inner edge of the frame all the way around. *Keep the cloth pulled evenly.* It is a good plan to tack one end first, then walk to the other

end and stretch the muslin from the first row of tacks while driving in the second row. Repeat this process on the sides. It is unnecessary to draw the cloth very tight in covering as the first coat of paint will shrink it somewhat. Do not fasten it to the braces. Space the tacks about 5 in. apart.

Remove the four temporary tacks in the corners and lay back the loose cloth. If the muslin has been properly secured to the wood, there should be a free flap 3 in. or 4 in. wide all the way around. This is pasted to the frame. To prepare an adhesive agent for this purpose, mix one pound of flake or ground glue in a quart of water in a pail and cook this on a stove until it is thoroughly dissolved. Be careful that it does not burn. If it does, people will be aware of the fact two blocks away. For safety's sake it is well to put the vessel inside another containing a little water, in the double boiler manner, with a small block at the bottom to prevent the inside pail from touching bottom. When the glue is liquid stir one pound of whiting into it.

Turn back the flap of muslin on the frame and apply the mixture, while it is still hot, to the wood evenly and generously with an old brush. Do not place any over the edge—one surface only. If the paste seems thin, let it set a moment before patting the cloth down on it. Use a rag dipped into warm water and wrung out to rub over the glued area to make sure the muslin sticks smoothly everywhere. Trim the superfluous fringe neatly with a sharp knife, and allow the glue to harden before attempting to paint.

Turn the flat over once more and apply the hardware. Place a lash line eye (or lacking that, a ½ in. screw eye) in the upper right-hand corner, a lash cleat just above the center brace on the same side, another one on the left side opposite a point half way between the first two plates, and two more, one on each side, 3 ft. 6 in. from the floor. Place brace cleats only on flats which need special bracing, such as those occupying a position in the center of a long straight wall or those holding door frames.

In an emergency 6-penny nails may be substituted for lash cleats and 1-inch screw eyes for brace cleats.

Cut a length of sash cord long enough to reach from the lash line eye to the floor, put one end through the hole in the plate, and knot it to prevent it from being pulled out.

A few suggestions. Be sure that all outside strips of lumber used in the frame, particularly the two side pieces, are perfectly straight. Warped edges make very awkward lashing in a setting.

Be sure at all times that the frame is absolutely square.

Before starting any construction it is recommended that the raw edges (called appropriately the "curse") of all strips be removed with a plane. This eliminates the great annoyance of splinters.

In building a whole set of scenery it is a good plan to cut all similar pieces from a model to prevent any errors that might result from inaccurate measuring. It is hard to conceive of anything more irritating

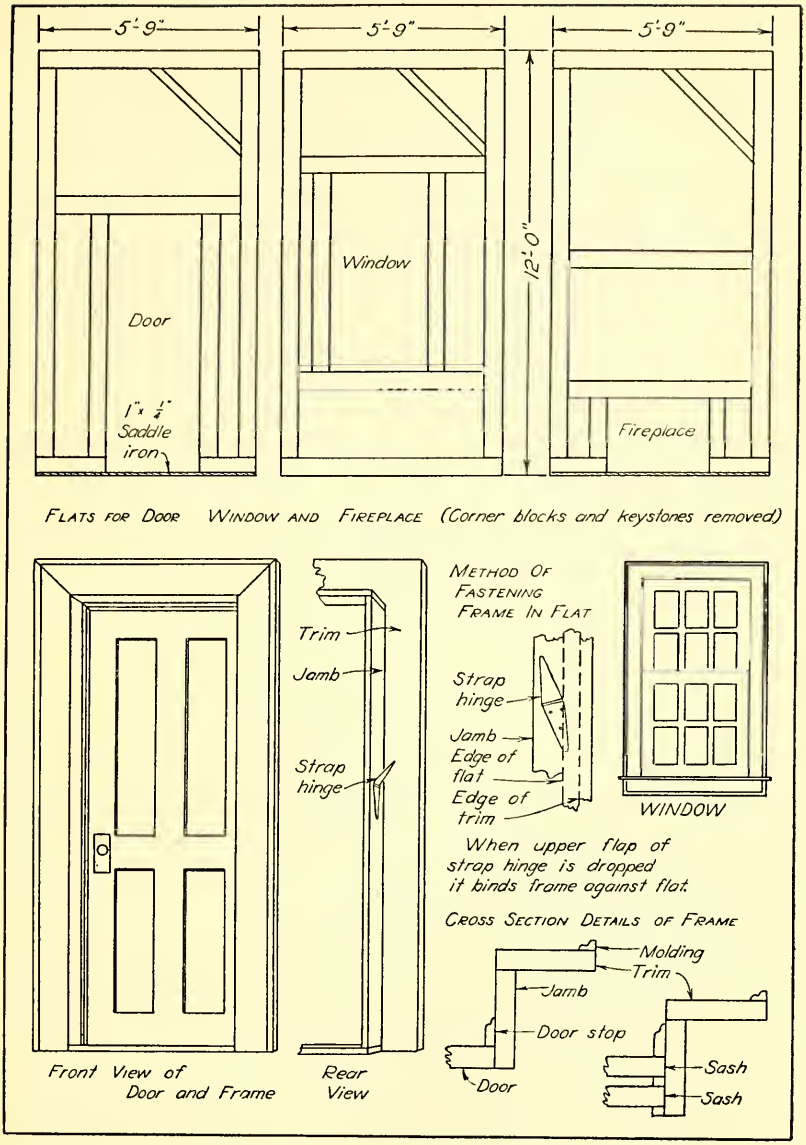



FIGURE 4: CONSTRUCTION OF FLATS FOR DOOR, WINDOW AND FIREPLACE. DOOR AND WINDOW FRAMES

than the discovery that a handsomely completed flat is just 6 inches shorter than its fellows.

Be sure that in covering you tack and paste the muslin over the face of the flat, not its back. Its face is its smooth side, without corner blocks, keystones, and hardware.

## 5. FLATS FOR DOORS AND WINDOWS

The construction of flats for doors and windows is the same as that of plain flats, except that for the former inner frames are added. In the flat for the door the center brace is raised to form the top of the opening, and two extra uprights are placed between this and the bottom rail. The part of the latter between the uprights is cut away. In order to prevent the two legs from racking, a 5 ft. 9 in. strip of 1 in. x ¼ in. iron, drilled and countersunk to accommodate No. 9 wood screws, is fastened to the bottom edge.

In the flat for the window one brace forms the top of the opening and another one the bottom. Corner blocks and keystones have been omitted in the diagram for the purpose of showing the arrangement of the various joints.

In covering, the muslin is stretched and tacked over the entire flat, then around the opening; the center is cut out and the flaps pasted and trimmed in the manner described in the previous section.

A common opening for a door for a small set is 7 ft. 7½ in. x 39 in., for a window, 5 ft. 4½ in. x 39 in.; but these are by no means standard sizes for the stage.

## 6. DOORS AND WINDOWS

A door unit consists of a solid door hung in a frame built usually of 5 in. or 6 in. x ⅞ in. white pine boards. The "frame" itself is built with a "box" or "thickness," the part that fits into the wall, and a "trim" or "facing" parallel to the surface of the wall at right angles to the thickness. The door is set back in the frame so that when it is closed it shows the thickness, and it is usually hinged so that when it is opened it will swing off and up stage.

A window unit, either "practical" (made to open) or "impractical" (fixed), is constructed in the same general way.

On both units a pair of 6 in. strap hinges (12 in. open, each flap 6 in.) are placed half way up, one on each side of the thickness. They are set at an angle, as illustrated, and only the lower flaps are screwed to the thickness, the upper flaps remaining free.

In setting the scene the free flaps are raised, the box part of the frame put through the opening in the flat, and the flaps of the hinges lowered to bind the frame against the 3 in. uprights of the flat. The trim, resting against the surface of the flat on the inside, prevents the frame from falling out.

In order to permit room for the hinges on the side and make it possible to lift door and window frames in and out easily, the openings in

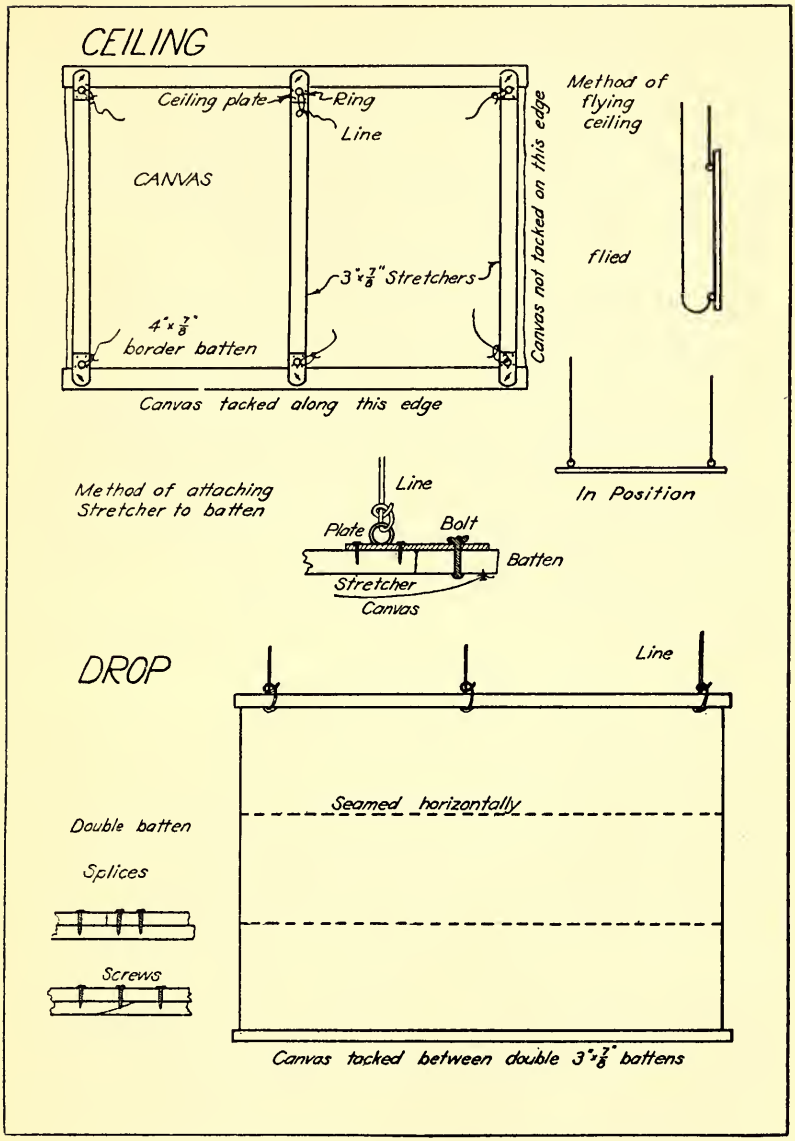



FIGURE 5: CONSTRUCTION OF A CEILING AND A DROP

the flats should be constructed a little larger than the thicknesses. Allow about 1½ in. clearance all the way around. That is, if the over-all measurement of the part of the door frame that comes through it is 7 ft. 6 in. x 36 in., the opening in the flate should be 7 ft. 7½ in. x 39 in.

Use screws instead of nails in putting together all important joints. As doors and windows, particularly the former, must be carefully fitted and be able to stand much hard usage, it is recommended that when possible these be built by a regular carpenter.

## 7. THE CEILING

Old-fashioned cloth borders may be used to mask the top of a set, but the modern ceiling piece is much more to be desired. Attached to two sets of lines, it is raised and lowered horizontally.

Its construction is simple. A large sheet of muslin, made by sewing together several widths, is fastened to a light frame of 4 in. x ⅞ in. and 3 in. x ⅞ in. pine battens. Ceiling plates, rings, or screw eyes are placed at convenient points along the up-stage and down-stage edges for attaching lines. Usually the cloth is tacked to the two long border battens only. Three-inch stretchers for keeping the cloth taut are bolted in place between these by means of ceiling plates, as illustrated. This method of construction permits the ceiling to be taken down and rolled up for storing away like a drop.

Three virtues which should be found in every good ceiling are: lightness, tautness, and size sufficient to cover the whole set comfortably.

## 8. DROPS AND BORDERS

Drops, if possible, should be made of duck canvas, as the material must be strong enough to support itself without the aid of a frame. To prevent wrinkling in hanging, seam the cloth horizontally. Tack the drop between double battens at the top and bottom, taking great care to avoid puckers. If the battens are not long enough to reach the full width of the drop, they may be spliced as illustrated.

Borders, little used now except for occasional foliage, are made as shallow drops. No battens are needed at the bottom.

## 9. STEPS AND PLATFORMS

The construction of steps and platforms is illustrated in Figure 6. Long or heavy flights should be made in unit sections which may be assembled and fastened together, where necessary, with loose-pin hinges. Platforms, likewise, should be as light as possible. If they are made of light tongue-and-groove pine boards and mounted on collapsible frames or "parallels," as illustrated, they may be taken down and struck into very little space.

To use the loose-pin hinges for fastening two pieces of scenery together, first knock the pin out and place one of the flaps on each of the units; then bring them together and drop an L-shaped wire into the hole to prevent them from separating.

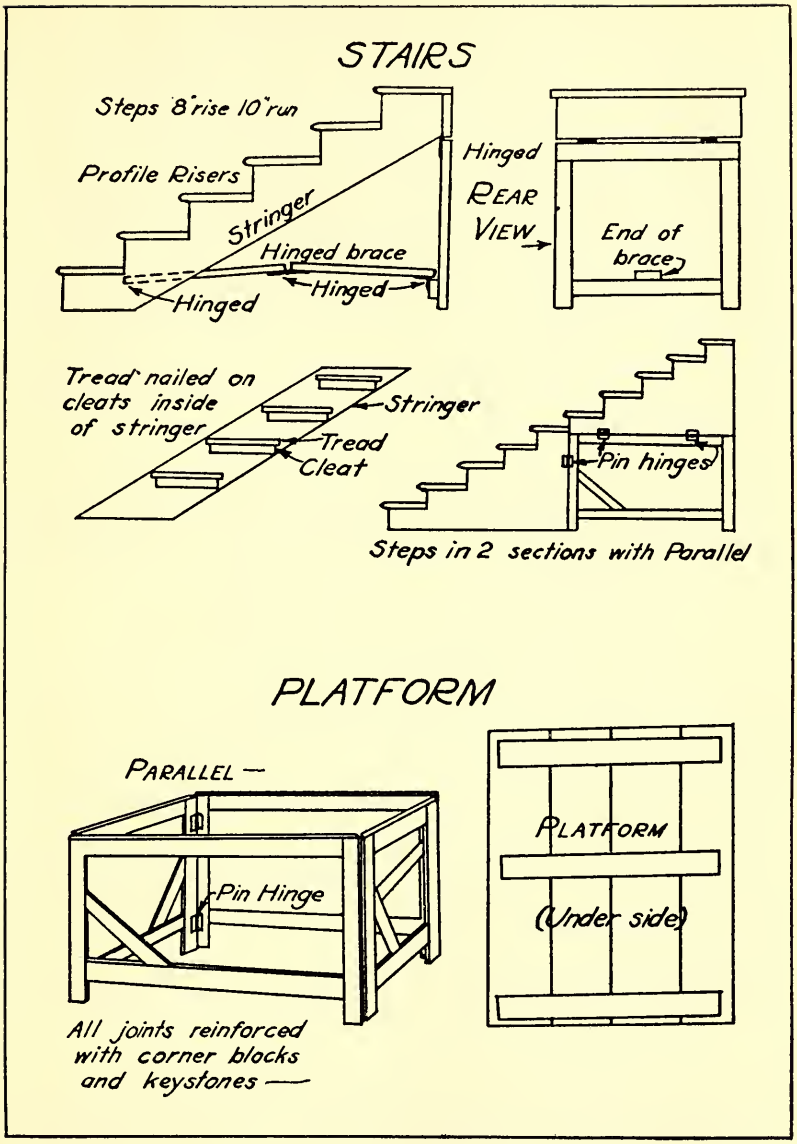



FIGURE 6: COUSTRUCTION OF STEPS AND A PLATFORM

## 10. OTHER PIECES OF SCENERY

In the limited space here it is impossible to do more than sketch suggestions for the putting together of other common pieces of scenery.

A fireplace is generally built out of ¼-in. ply board or beaver board nailed over a frame and trimmed with a little moulding.

A column is constructed of the same materials nailed over a framework of half-rounds, and is made to stand firmly on the stage by means of a prop, called a stage brace, attached behind.

Frame trees, as well as imitation rocks and stumps, consist of chicken wire tacked over irregular wooden frames and covered. Small pieces of scrap muslin and other rags are dipped into the hot-glue-and-whiting preparation described in the section on the flat, and pasted over the surface of the wire.

A collapsible tree is made of painted canvas or muslin pleated and tacked around half-rounds at top and bottom and suspended on a rope from the flies.

A ground row, used to represent the profile of a bank of earth, distant mountains seen through an open door, etc., is constructed of a painted strip of veneer or beaver board nailed to a flat frame and cut out with a keyhole saw. It is made to stand up by means of an angle iron or triangular jack hinged to the back.

## 11. THE VALUE OF EFFICIENT SHIFTING

As has already been remarked, one of the prime requisites of good scenery is that it be fixed to shift rapidly. Folks come to a theatre to enjoy a performance, not intermissions; consequently the latter should attract as little attention as possible. No change, however difficult, should occupy more than twelve minutes at most. Ten minutes is the average intermission between acts and two to four the average between scenes within acts.

It will readily be seen how necessary is the planning of methods for handling a set of scenery during its "setting" and "striking." As far as possible these should be thought out before the units of a set cause annoyance.

are built so that an awkward piece can be modified before it starts to

In the following section are outlined some of the common practices followed in hanging and setting scenery.

## 12. METHODS OF LASHING AND BRACING SCENERY

Two flats placed edge to edge are bound together by means of "lashing." The method is illustrated in Fig. 7. The lash line hanging from the right upper corner of one flat is grasped with the right hand, tossed over the upper lash cleat on the other flat, back over a cleat on the first, then carried down over the lower one on the second, around the cleat opposite it on the first, and back to the right. The free end of the line is now passed under the prostrate portion and pulled down

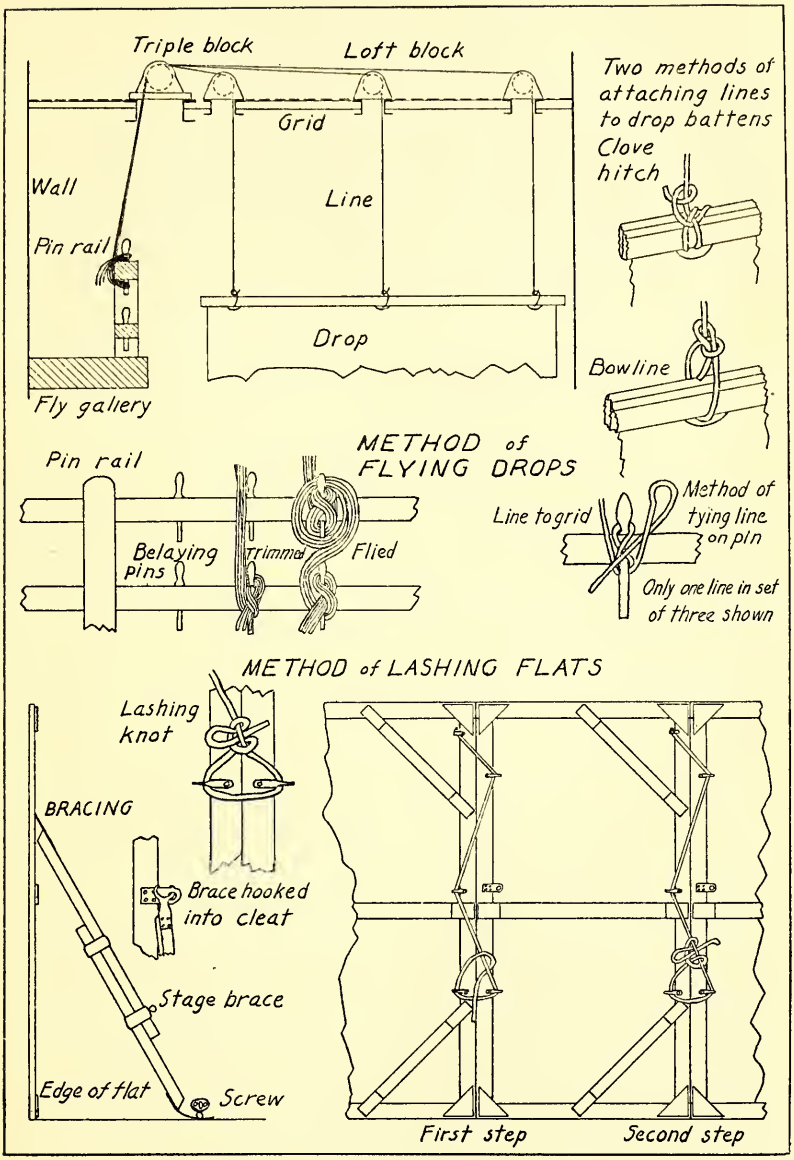



FIGURE 7: METHODS OF FLYING AND BRACING SCENERY

snugly to tighten the lashing. While the left hand holds the rope taut, the right hand lifts the free end and passes a loop of it under the prostrate portion once more to tie a slip knot. To loosen the lashing it is necessary only to pull the free end of the line.

Flats needing special strengthening, such as those on the edges of a set, in the center of long straight walls, or holding doors or windows, are made secure by being propped up behind with stage braces. The brace is hooked into a brace cleat placed on any convenient part of the flat about 6 feet from the floor, then twisted so that its prongs clinch the plate as shown in Fig. 7, and pegged firmly to the floor with a stage screw. An adjustment screw permits the lengthening or shortening of the brace.

Units which cannot be conveniently lashed, such as steps and platforms, we have already described in Section 9 as being fastened together by means of loose-pin hinges.

## 13. METHODS OF FLYING SCENERY

In order to fly scenery it is necessary to have some arrangement for hanging ropes from above. Every well-equipped stage has a grid (see Fig. 7) extending over the entire working space and high enough to permit drops being lifted out of view of the audience. The flies on some professional stages reach over 100 feet above the floor. Loft blocks on the grid are arranged in rows, usually three in each, at regular intervals from the curtain line to a point well up stage. Sets of lines tied to the center and two ends of each hanging piece of scenery are passed through these blocks, over a second set of sheaves in head blocks directly over the fly gallery, brought down, and tied off on the pin rail.

One attaches a line to a drop, or other hanging piece, by tying a clove hitch or bowline around the upper batten. The three ropes in a set are called respectively the "short,' "center," and "long line" as they are fastened to the near end, middle, and far end of this batten, from the point of view of the fly man.

There are two rows of belaying pins on the pin rail: the lower one for tying the drop at trim when it is in position in the set and the upper one for tying it when it is raised into the flies. This method of using the rail is found serviceable when a piece of scenery must be lifted and lowered during a performance. Trimming takes time which can be ill afforded during a quick shift. However, by using the two pins, this can be done beforehand. The lower tie remains permanent. When the appropriate scene arrives the flyman loosens the ropes from the upper pin, lets them slide through his fingers, and when the slack is out he knows the drop or other hanging unit is automatically in position. The proper way to tie lines is shown in Fig. 7.

A small sandbag or any other weight should be tied into every free set of lines to prevent the ropes being pulled through the blocks when

drawn up out of the way, and to permit them to come down again with their own weight when released.

On small platform stages where there is no possibility of constructing a regular grid a few pulleys may often be fastened to beams in the ceiling. If steel I-beams, parallel to the ceiling and perpendicular to the proscenium, are placed between the latter and the back wall, standard underhanging blocks may be used. Minimum equipment includes two sets of pulleys or blocks to take care of the front and back edges of the ceiling, and another set to support the sky drop up stage. If the scenery is light the lines may be tied off on a row of common lash hooks fastened to a board nailed to the wall at the side of the stage.

A word of caution. *Be sure that all hardware and knots used in flying are secure.* Some serious accidents have resulted from pulleys or sandbags breaking loose during a performance. Safety is the first law of the stage, as it is everywhere else.

## 14. SETTING THE SCENE

To set the usual box interior the ceiling is hung first and lifted high enough to clear the flats; then the latter are lashed together in position, starting with one down-stage end and proceeding in order around to the other, stage braces being used where necessary. Door and window frames are put into appropriate openings, and clamped in place with their strap hinges. The ceiling is let down again, trimmed, and tied off on the lower pin rail. Lastly, backings are placed behind doorways and the sky drop is lowered.

To strike the scene, the ceiling is lifted two or three feet and a second tie in its lines made on the upper rail. The process of setting up is then reversed.

The handling of exteriors is not so uniform. They seldom follow any kind of standard design and consequently, in being fitted to the stage, they are apt to call on the ingenuity of the artist or the carpenter rather strongly. An exterior setting generally contains a sky drop in front of which stand fences, trees, or the ends of buildings. Painted ground rows, representing banks of earth or distant mountains, conceal the lower batten of the sky; screens of foliage, the corners of other buildings, or tall rocks may hide the exposed wing spaces on the sides. If the sky drop is narrow, it is often advisable to drag one end around on a bias with an extra line. As no ceiling can be used in an outdoor scene, it is necessary to mask the flies with some sort of inconspicuous border, generally cut-out, representing a limb of a tree or a few large masses of foliage in silhouette.

*Speed* and *efficiency* are two words which should never be out of mind wherever scenery is handled. Each shift should be plotted out carefully ahead of time and rehearsed until the station of every man and the sequence of his movements become absolutely clear. As far as possible, standardize all methods and procedures. "A place for

everything and everything in its place," should be a motto tacked up prominently on every amateur stage.

## 15. THE PAINTING OF SCENERY

There is little work associated with the technical department of play production more fascinating than that of scene painting. To the uninitiated it often appears to be a mysterious and wonderful art; the ability to daub and splash colored wash on flat canvas with an eight inch brush and make the result look from a distance like a rough plaster wall, or sky, or mist-covered mountains seems little short of a magic one. It is assumed that the process of securing such extraordinary effects must be hard and complicated. As a matter of fact, they are usually quite the contrary. To become a completely accomplished artist of the stage demands, of course, many years of studying; but to learn to conceive and paint simple, attractive settings for the plays presented by most high schools and small dramatic clubs is no very difficult achievement. For this work, some understanding of drawing and composition, and a good eye for color, are essential. Anyone, however, who has done free-hand sketching and who has painted in water colors should pick up the tricks of handling the larger medium of wood and canvas without great trouble.

The first "trick" the artist learns is, obviously, to exaggerate. All painting for the stage must be done in a bold and free manner. Impressions are made at a distance. Fussy details of design and color do not carry, and are consequently lost upon an audience. The smallest brush in common use in scenic work is the two-inch, and the more serviceable ones measure from six to ten. It requires some courage to use these at the start and a considerable amount of experimenting must usually follow before they feel altogether friendly to the hand. But in time they become as easy to manage as little brushes.

Another "trick" that must be learned is to paint for stage lighting. The latter has a tendency to change not only the quality of color but its intensity as well. Consider its effect upon make-up. "To appear to be natural from the position of the audience one must be unnatural on the stage" is a truth which was most forcefully proved for the writer when he saw Mr. Cleon Throckmorton, at that time art director for The Provincetown Playhouse in New York, apply brilliant touches of green, red, and blue to the leaves of a real rose vine in a garden set to make the plant look from the audience like something more healthy and expensive than the pale weed it appeared to be before.

The artist will find it helpful to paint his scenery on the stage or in a large room where he can from time to time walk off twenty or thirty feet and "squint" at his work to get the effect of distance, so illuminated that he can test his colors under lighting conditions similar to those to be used in the performance.

Scene painting can really be learned only through experience. Beginning artists should not be discouraged if at first they find they

have to do considerable experimenting to arrive at the effects they wish to secure. Fortunately, scene paints are both opaque and cheap and one coat may be washed on top of another as long as glue will hold to the muslin.

## 16. MATERIALS REQUIRED

**Scene Paints.** Distemper, or water color, is employed almost exclusively on the stage, its advantages over oil being that it is applied easily and quickly, it dries rapidly, it does not shine, it is cleaner to handle, and it is far cheaper. That known as *scene paint* is the pure pigment in powder form. Before it is used it must be mixed with glue and water. It is sold in fifty or more colors. Some of the most serviceable ones are listed below with their approximate price per pound.

| | |
|---|---|
| Ultramarine blue | $.35 |
| Venetian red | .12 |
| Raw sienna | .12 |
| Burnt umber | .12 |
| Yellow ochre | .15 |
| Chrome yellow | .25 |
| Chrome green | .25 |
| Drop black | .25 |

Other useful colors, some of which cost a little more, are: cobalt blue, Italian blue, burnt sienna, vermilion, orange mineral, emerald green, and Hanover green.

**Whiting.** By far the most useful color for the artist is ordinary whiting. He should estimate that he will use as much of this color as all the rest put together. Whiting may be bought at nearly every paint and hardware store, costs from three to four cents a pound, and is mixed like any of the other colors.

**Glue.** Flake glue is preferable to ground glue, though both may be used. These must be cooked. Le Page's, which needs no preparation, may be employed in an emergency; but its cost will prevent it from being more than a very occasional luxury.

**Brushes, etc.** For painting scenery four brushes will be found serviceable: one 8 in. and one 6. in. for "priming" and covering large surfaces evenly and rapidly; one 4 in. for "laying in" smaller areas; one 2 in. for details; and one 1 in. for lining. They should all be of the long-bristled variety used in kalsomining. Brushes deteriorate very rapidly unless care is taken of them. After every painting they should be rinsed, shaken out, and laid to dry in a flat position.

Other useful tools for the artist are: a yardstick, charcoal, a 16-foot length of heavy cotton cord and a 6 foot batten with a perfectly straight edge for occasional ruling. He must also have a number of 6-quart pails, a few smaller pans, and the use of an electric or kerosene stove with two or three burners.

## 17. THE PREPARATION OF PAINT

Pigment powders are mixed with a solution of glue called "size water," made as follows: 4 pounds of flake (or ground) glue are placed in a 6-quart pail of water, allowed to soak for about an hour, and then cooked on a stove. The pail must be placed within another with a little water and a block of wood or a brick in the bottom of the latter, double boiler fashion, to prevent burning. When completely dissolved the glue is further diluted to make size water. Four pounds of dry flakes will make 4 to 6 pails of size water. The more concentrated preparation may be kept as "stock" to be diluted as needed. As time must be taken to remelt it whenever this is used, however, it is wise to make up several buckets of size water at a time to prevent delay in painting.

The glue solution should be warm when the pigment is added. Pour the powder into it slowly, stirring it thoroughly to prevent lumping, until the mixture has the consistence of a heavy cream. It is difficult to give any very exact proportions for mixing scene paints, as both glue and pigments vary. Veteran artists judge largely by the "feel" acquired through experience. If too much glue is used, the paint when dry will draw and crack on the surface of the muslin; if too little, it will powder on the hand rubbed across it. If too much pigment is used, the paint will seem stiff and heavy in brushing and one stroke will have a tendency to pile up on top of the preceding one; if the mixture is too thin, it will look transparent on the canvas.

The paint should be applied at least slightly warm, and the bucket should be stirred from time to time to prevent the powder from precipitating to the bottom. If the pail is set aside for a while and grows cold, it should be thoroughly stirred and placed again on the stove, care being taken that its contents do not burn.

A word of caution should be given to those experimenting with scene paints for the first time. Water colors invariably look darker when wet than dry, mixtures containing white being especially tricky deceivers in this respect.

It is difficult to match blends. Before painting the interior walls of a set, therefore, it is wise to mix enough paint to insure its not running short at some strategic point. Two 6-quart pailfuls will take care of a 12-ft. seven-flat set very nicely.

## 18. THE "PRIME COAT" AND OTHER COATS

The first coat of paint is called the "prime coat." Its purpose is to close the pores of the muslin and prepare a working surface for the following painting. As whiting is the cheapest powder, it is usually used; but any pigment may be employed equally well. Left-over scraps from the previous day's painting may be boxed together and warmed up to prime the new flats. The only directions for applying this coat are to use a large brush and to spread it evenly, smoothly, and not too thickly.

One coat of paint should be allowed to dry thoroughly before the application of another, or the damp pigments will mix and produce muddy spots.

If the paints are properly mixed, one coat will completely opaque the preceding one. If it does not, it is probably too thin. If one coat picks up another, the fault may lie in one or more of three possibilities; the fresh paint is too warm, that beneath it is still damp, or the latter lacks glue. A little experience will quickly teach one how to avoid these annoying conditions.

## 19. METHODS OF APPLYING PAINT

The following are the most common methods of applying paint to scenery.

**Flat Painting.** Obviously the most simple method; useful for priming and laying on ground colors.

**Scumbling.** A fairly dry brush is passed lightly over the surface of the muslin in various directions in such a way as partly to conceal the color underneath—without, however, producing an effect of undue blotchiness or streakiness.

**Sponging.** A large sponge, trimmed to present a flat surface, is dipped into a pail of paint, squeezed out, and patted gently over the muslin. Care should be exercised in this method, too, to cover evenly and avoid spottiness. The textural pattern should be continuous. It will be found helpful to pat in spirals or semicircles and to turn the sponge constantly in the hand.

**Cloth Rolling.** An effect similar to the above can be secured by dipping and wringing out a ragged piece of coarse burlap and either patting it or rolling it over the surface to be covered.

**Spattering.** The most useful for producing broken-color impressions, this method is often combined with scumbling. A brushful of paint is shaken over the muslin or snapped so that the paint falls in little drops. To insure evenness it is well to start with one end or corner of a piece or group of pieces of scenery and to proceed systematically to the opposite one. Avoid dribbling from an over-wet brush and dropping large spots which show themselves up as paint and destroy the illusion of texture.

If the walls of a setting or other group of pieces which must be used together are to be painted by one of these methods, it is imperative that they be laid side by side in the proper order on the floor and done as a unit to insure matching.

The suggested solutions of various problems that follow should be appreciated as hints only for beginners, to be modified or disregarded as one discovers better methods.

## 20. INTERIOR AND EXTERIOR WALLS

The principle of broken color may be used in developing wall surfaces which are intended to appear either smooth or rough. For the

first surface, which of course suits interiors better than it does exteriors, choose two or three colors which are nearly alike, such as blue-gray and yellow-gray; or light-cream, dark cream, and light brown. Lay one of the colors in solid as a ground coat; when it is dry, spatter the second evenly over the first until it nearly conceals it; then spatter the third over these two in the same manner. If the spattering has been properly done, it should present a surface which from a distance at first sight will seem to be perfectly smooth but upon closer examination will be seen to have just enough texture to prevent its looking chalky.

The use of more widely separated colors in spattering will suggest stucco. If two or more colors are applied cleverly enough by the cloth-rolling method, a very convincing effect of old wall paper may be produced. If a more pronounced design is desired, simple figures may be cut in oiled paper and stenciled on the wall. Avoid any very conspicuous patterns or they will probably refuse to lie at rest on the surface. If the figures appear too vigorous when viewed from a distance, spatter them over lightly with a little of the ground color to tone them back into the rest of the wall. Remember at all times that good scenery acts as a background and does not intrude into the play.

Sponging, another popular method employed in treating interiors, may be combined with either, or both, spattering and rolling. If carefully handled, quite dissimilar colors may be used together to produce interesting blends.

Old stained plaster, particularly effective for exterior walls, may be suggested by scumbling and blocking-in large irregular patches of various light and dark browns and a little blue, and spattering this all over, when dry, with a couple of shades of gray. Keep the heaviest tones near the floor. As dark blue under the prevailing straw and amber lights of the stage looks black, a little ultramarine may be mixed with a small amount of black and sprinkled *very lightly* here and there over the plaster to suggest holes and crevices. Guard against large drops or you will give away your secret.

Brick walls should be handled thoughtfully. Rows of regular red rectangles with straight white lines between, seen so often on amateur stages, never look very real. Even the most evenly laid walls in real life show many irregularities and signs of weathering. One good plan to follow in painting is to scumble your plaster in first as a ground coat—not in one tone but in two or three slightly different ones—and then to lay your bricks in lightly on top of this with a comparatively dry brush. Vary red with a little neutral orange, brown, and blue. It is well to keep the bricks in fairly straight lines, of course, but do not attempt to paint them too regularly. Knock off a corner here and there and touch occasional edges with darker blue to suggest stains. Keep in mind that an *impression* is what

you are trying to create, and that fussy details have no meaning for the audience.

## 21. SKIES AND LANDSCAPE PIECES

A large drop, high enough and wide enough completely to back up all exterior views and painted pale blue, is used to represent the sky. As it depends chiefly upon lighting for its effects, its own tinting should be very soft. Mix not more than two or three ounces of ultramarine, cobalt, or Italian blue in a full pail of white, and apply it with a large, absolutely clean brush, taking great care not to streak it. If it is a large drop, prepare two buckets of paint and box them thoroughly before starting. To run short and to attempt to match new tints in the center of the sky is indeed disastrous.

The old fashioned practice of painting landscapes on a sky drop is now generally frowned upon by the best artists. Besides being difficult to do, it never produces very convincing results and it limits the use of the drop. A simple sky may be used in every act of a play with an exterior view, while a painted landscape fits into the locality of only one scene.

The character of an outdoor setting is better suggested by a few plastic "set" and "built" pieces, such as ground rows, silhouette hills, rocks, trees, and fences placed in front of the sky. The construction of these is described in the previous chapter. In painting them it is well to keep in mind that, except possibly for the sky on a cloudless day, there are no large masses of flat color in nature. Even a simple tree trunk will show a surprising number of colors—perhaps a dozen or more browns, grays, blues, and greens. Of course it would be impractical to indicate very many of these, but use at least two or three tones to prove that a piece of scenery is a tree trunk and not a painted post.

Keep colors as light as possible; vary tints and shades; avoid black shadows; and remember that blue and violet suggest distance. A little pale ultramarine spattered on a row of hills will make it seem to sit ten miles closer to the horizon.

## 22. ART AND THE BUDGET

To conceive perfection in scenic design is one thing; to achieve it, another. Those of us who must labor in the theatre with one hand on the stage and the other stretched to the slim tin box in the business manager's office realize, often only too keenly, the truth of this statement. Under the emergency conditions occasioned by temporary or chronic budgetary depression, wise practice demands, of course, a compromise. It is a compromise, however, not of purpose but of method.

I have often been asked by the directors and technicians of small school and community producing groups what an ambitious artist is expected to do when he is allotted from the treasury for the preparation

of scenery, not one or two hundred dollars, but a meager ten! My reply to this troublesome question is contained in one or two general suggestions. They must be considered as hints only, because the ultimate solution of each emergency problem in scenic design is naturally

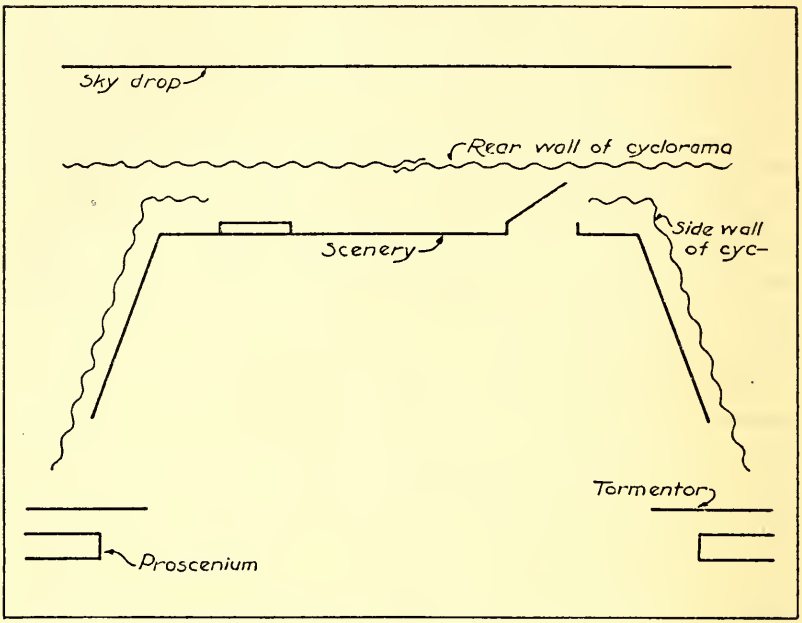



FIGURE 8: A PLAN FOR MINIMUM SCENERY

*Small set-pieces of scenery are placed in front of a black drapery cyclorama. The cyclorama, in four sections (one attached to a wooden batten on each side and two attached to a wooden batten at the rear), is suspended on lines run over pulleys in the gridiron or stage ceiling. The rear wall may be hung close against the ends of the side walls, but there is some advantage in having space between them, as indicated in this diagram. The arrangement shown above is especially useful where a sky drop is included in the equipment. The sky is uncovered by flying the rear wall of the cyclorama, or by tripping up the two rear sections with snatch lines.*

influenced by specific circumstances, and must, therefore, be handled in terms of itself.

Any program of economy related to the stage usually involves some form of initial investment. The particular "money-saver" which is here recommended for purchase or construction by the artist required to provide a quantity of scenic environments on a frail allowance, is a black duvetyne, rep, or velour cyclorama. Hung

around, and behind, the acting area on the stage, the cyclorama is employed as a neutral background for small screens and other low-cut scenic forms placed in front of it. It is surprising what attractive, dramatically effective, and at the same time inexpensive settings can be produced with this combination of black curtains and painted set pieces.

The cyclorama should never, of course, be used by itself alone—except for occasional purely spatial settings. Black, unrelieved by color, is depressing and a view of it soon grows tiresome to the spectator. The "feeling" of a cyclorama setting is almost invariably imparted by the decorative and dramatic objects placed in front of it. Black curtains on the stage should, therefore, be regarded purely as contrivances for masking from the audience the sides and top of the stage, and for providing a neutral, or spatial, background for the scenery proper.

If a sky drop is hung behind the cyclorama and is revealed for out of door settings by parting the two rear sections of the hanging drapery or, preferably, by raising these sections into the flies, greater contrast may be secured between "inside" and "outside" scenes. A suggested arrangement of cyclorama and sky-drop units for the ready accommodation of all kinds of abbreviated scenery is indicated in Figure 8.

Regarding the cost of the initial investment—a duvetyne cyclorama designed for a small stage, consisting of four sections (two for the back and one each for the sides), two borders, two tormentor-tabs, tie-lines, and a batten frame, may be made for $30 to $100. Rep and velour curtains are heavier and stronger, but they are also priced a little higher. A muslin sky-drop might require the outlay of another $10 or $15. Whatever the expense of these two units is, the producer may rest comforted in the knowledge that he will soon save several times their cost in lowered scenery bills.

PART VII

# STAGE LIGHTING

*By* Harry E. Davis

## INTRODUCTION

Lighting is today the most valuable tool in the hands of the theatre artist. It is likewise the most difficult and the least understood phase of production confronting the non-professional theatre worker. In the last few decades electric lighting has had a phenomenal development, and a staggering variety of stage lighting devices is now on the market. The rapid advances which have been made in both means and methods are an integral part of our modern age of mechanical glory, but they leave the uninitiated producer in a state of confusion, and even of despair. It is the aim of this section to assist the beginning stage lighting artist in orienting himself in this mechanical maze.

Until a few short years ago light was used in the theatre almost universally for a single purpose—visibility. Light illuminated the actors, and allowed the audience to see the play. This is the primary function of light in the theatre, and the beginner should not lose sight of the fact. Occasionally some professional producers, eager to play with their elaborate new equipment, forget the fundamental function of light when they underlight their plays for the sake of "mood." On the other hand, many amateurs, limited to a few footlights and overhead units, and lacking experience, go too far in the other direction, and overlight their productions with a great glare of white light. Obviously neither of these extremes is good lighting. They put a strain on the eyes of the spectators, and destroy the value of light. All good stage lighting must be first of all comfortable to the eye.

With the marvelous recent development of comparatively cheap, but highly efficient, lighting units the stage lighting artist is now able to add to his "visibility" lighting many other valuable qualities. With color devices he has the tremendous advantage of breaking up white light and selecting a great variety of hues for his lighting palette. With various sizes of lamps and efficient dimming apparatus he may control the intensity of the light given out by any single unit. By use of lenses, hoods, spill rings, and numerous other devices he may fairly well control the direction and concentration of light. Hence light may now be used not simply to make the play visible, but also to suggest to the spectator the time of day or of year; to reinforce the color values of the scenery, costumes, and make-up; to create visual interest by contrasting light and shade; to strengthen the psychological effect of the play by intensifying its mood; and last, but most important, it may unify the play by interrelating its visual elements in the proper proportions. However, despite the many subtle aids which lighting may give to the imagination, it should never be allowed to dominate the dramatic action, except in the rare instances

Two outdoor scenes staged, one in The Forest Theatre, and one in The Playmakers Theatre. Above: the patio in Alvarez and Joaquin Quintero's *The Women Have Their Way*—directed by Harry E. Davis. The scenery and costumes by Ora Mae Davis. Notice how effectively the outdoor setting is blended with the surrounding trees. Below: the desert in James Milton Wood's *Death Valley Scotty*, designed by Elmer Hall.

Cut-down scenery backed by a black cyclorama. The setting for Wilkeson O'Connell's *The Loyal Venture* by Mary Dirnberger (above). The setting for Philip Milhous's *Davie Crockett* by Marion Tatum (below). The scenery for each set cost less than ten dollars. The plays were written in the University Playwriting Course.

where such is the intention. The play is the thing, and lighting is its handmaid.

## A WORKING DICTIONARY

An elementary working knowledge of the physical principles of electricity and light (electromagnetic energy) is the minimum requirement for the safe and efficient operation of even the simplest stage lighting equipment. Unfortunately most text-books on stage lighting and especially on physics bewilder the beginner with their length and mathematic intricacies. The sad truth is that these involved laws and principles must be thoroughly mastered before modern lighting equipment may be gracefully used as a tool of the theatre artist; otherwise it will remain an unwieldy burden.

The following definitions and discussions are offered as a very elementary text to assist the beginner to take hold. They are by no means a thorough discussion of the matter, nor even entirely accurate as far as theoretical physics is concerned. As the student becomes more and more familiar with both principles and equipment he will find it necessary to make a more extended study in some standard text on stage lighting or on physics. For the latter subject a high school text-book will be most easily comprehended by the novice.

### *Electricity*

*Electricity* is a form of energy. It may be transformed into other forms of energy such as heat, light or motion. Conversely heat, light or motion may be converted into electrical energy. For stage purposes electric energy is most often converted into light, though occasionally it is converted into heat for cooking, or into motion for the operation of motors. Commercially, electricity is generated in large power plants, and transmitted over wires to sub-stations, from whence it is delivered again over wires to individual consumers.

*A conductor* is any substance which will allow electric current to flow easily through it. Commercially, copper wire is the most commonly used conductor.

*An insulator* is any substance which prevents (or nearly prevents) the flow of electricity. Rubber, porcelain, cotton fabric and dry slate are insulators used commercially. Any substance, such as the thin german silver wire used in stage dimmers, which permits electric energy to flow through it, but which has a tendency to retard or resist the flow, may be called *a resistance.*

*Measuring units and Ohm's Law* (See page 66). The qualities and behavior of electric currents flowing through conductors are usually explained by likening them to water currents flowing through pipes and plumbing equipment. Such an analogy is valuable as an aid in picturing mentally the behavior of this invisible energy, but the comparison is not for identification of the two phenomena; water is matter, and electricity is energy.

Water flowing in a pipe has pressure—it flows from a high level of

## OHM'S LAW

*The intensity of an electric current moving along a conducting path is equal to the electromotive force divided by the resistance.*

For practical stage purposes, Ohm's Law may be interpreted as follows: *The amperage in a circuit is found by dividing the voltage by the number of ohms resistance.* Using a mathematical equation:

$$\text{amperes} = \frac{\text{volts}}{\text{ohms}}, \quad \text{or, volts} = \text{amperes} \times \text{ohms, or,}$$

$$\text{ohms} = \frac{\text{volts}}{\text{amperes}}.$$

Since most stage lighting equipment is not rated in ohms, but is practically always rated in watts, or power consumption, a more useful form of Ohm's Law is the power formula, *watts equal volts times amperes.* Mathematically:

$$\text{watts} = \text{volts} \times \text{amperes, or volts} = \frac{\text{watts}}{\text{amperes}}, \quad \text{or,}$$

$$\text{amperes} = \frac{\text{watts}}{\text{volts}}.$$

## APPLICATIONS

Ohm's Law is indispensable to the stage electrician in determining the proper set-up of a circuit. In using any of the above equations, we have only to know any two values in order to determine the third value. For example:

Suppose we wish to use a 1000-watt floodlight on a current of 110 volts, having ascertained that the latter is the voltage supplied to us by the power company. We know from the power formula that amperes equal watts divided by volts; hence, dividing 1000 by 110, we find that our floodlight will draw a little more than 9 amperes of current. We therefore make sure that we have a ten-ampere fuse protecting the circuit; that all wires in the circuit have a capacity of at least 15 amperes (minimum Code requirement), and that all switches, sockets, etc., have 15-ampere capacity.

Suppose we are curious to know what the resistance of the above lamp happens to be. We know that ohms equal volts divided by amperes; hence, by dividing 110 by 9.09 (the amperage determined above), we learn that the lamp offers a little over 12 ohms of resistance.

Suppose we have a circuit composed of several various-sized lamps in the footlights. If there are three 40 watt lamps, two 60 watt lamps, and one 50 watt lamp connected in parallel, we have a total wattage of 290. The voltage is 110, and the amperage is found to be 2.6 plus. We therefore protect the circuit with a 5 ampere fuse, since this is the nearest practical size manufactured.

pressure to a lower one. Similarly electric energy tends always to flow from a higher level to a lower level, or as the physicist puts it, from a higher to a lower *potential.* The push, or pressure, which causes electricity to flow from a higher to a lower potential is called *electromotive force* (*e.m.f.*), and it is measured in a standard unit called the *volt* (*v*). Commercially, electricity is sold to consumers at a constant pressure or voltage, just as water is supplied to dwellings at a constant head. The usual voltage ranges around 110, and most electric equipment is designed to operate efficiently at such voltage. All electric equipment, however, is marked to show its rated voltage, and the label should always be checked to see if the voltage (v) is the same as that supplied by the power company. The supply voltage will be clearly shown on the company meter, or may be learned by inquiry.

The *rate of flow* of an electric current, which physicists call its *intensity,* is measured in a standard unit called the *ampere* (*amp.*). The *amperage* of an electric current is analogous to the cubic feet per second used in measuring the rate of flow of water currents.

Whereas the voltage supplied to a building will remain always the same, the amperage will vary according to the number and size of the equipment in actual use. Similarly the pressure in a water line will remain constant, but the rate of flow will depend on the number and size of faucets in use at any given time.

Water flowing through a pipe is retarded by friction against the pipe; similarly electric energy flowing along a conducting path is met by *resistance,* and this resistance is measured in a standard unit called the *ohm.*

Since we have to pay for electricity we are interested in the amount of work it will do. The standard unit used to measure *work done,* or *power,* is the *watt.* As this is a small unit, electricity is sold in a larger unit, the *kilowatt,* or thousand watts. One kilowatt is equal to 1.341 horsepower.

*Alternating and Direct Currents.* An electric current flowing constantly in one direction is known as a *direct current* (*D.C.*), and one which reverses its direction at regular intervals is called an *alternating current* (*A.C.*). Most electricity is sold in the latter form, since alternating current is the easier form to generate, and since most equipment will operate as efficiently with A.C. as with D.C. Unless the abbreviation A.C. is clearly marked on such equipment as motors, certain types of arc lamps, and other carbon arc units, they should not be operated on alternating current, until it is ascertained that damage will not result therefrom.

Alternating current reverses its direction in regular intervals, and such intervals are measured in *cycles.* The average alternating current is supplied in 60 cycles, which means that the current moves through a complete alternation cycle sixty times in each second. The

cycle of a power supply is important in the operation of motors, which are designed to operate efficiently at a particular cycle. The cycle supplied will be clearly shown on the company meter, and should be checked against the proper operating cycle of the motor.

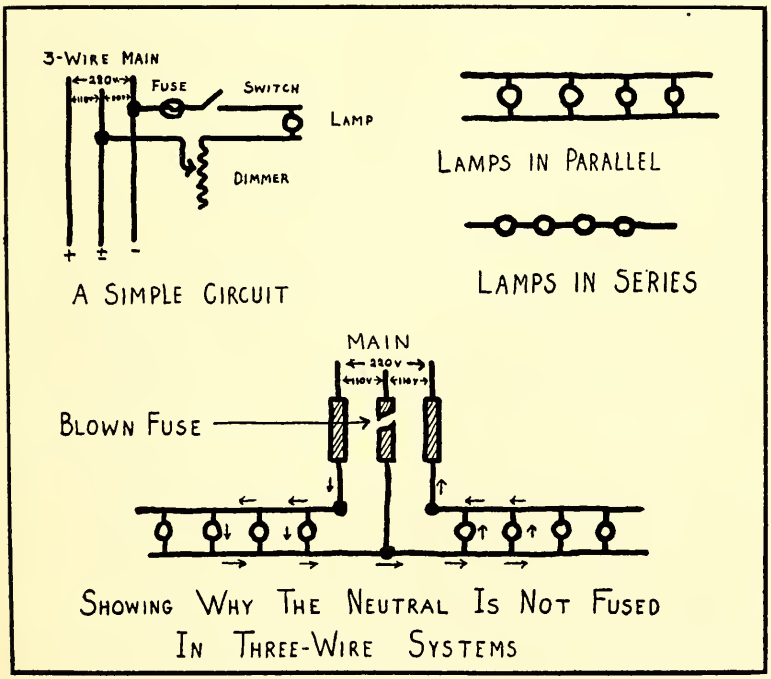
*Circuits.* Electric current will not flow unless it is offered a *conducting path,* and any such conducting path is called a *circuit.* When this complete path is continuously connected together without interruption, the circuit is said to be *closed.* When any part or section is separated, so that the current may not travel through the circuit, the circuit is said to be *broken,* or *open.* A copper wire across the terminals of a dry battery would be a simple circuit; but such a circuit would be of little use to anyone. To transform flowing electric energy into light, heat or motion, various pieces of apparatus are made a part of the circuit, that is, they are *introduced into the circuit.* If we connect an incandescent lamp to two copper wires, and in turn connect the wires to the main current supply, we have a circuit which transforms electricity into light. The current flowing through the circuit meets resistance in the tungsten filament of the lamp, the filament heats up to incandescence, and light is given off. If we place a *switch,* a movable copper bar, in the circuit, we can open or close the circuit at will. Also, by introducing into the circuit a piece of soft wire, with a low melting point, we may protect the circuit in case the current accidentally becomes too great for safety, for the soft wire, or *fuse,* will melt and open the circuit.

In common wiring practice the wire carrying current toward an instrument and the wire carrying current away from it are combined into a common *two-conductor cable* which keeps each wire insulated from the other and from outside contacts, but which allows them to be conveniently handled together. Any contact between the two sides of a circuit, either directly or by means of any good conducting medium, which may occur before the current has reached the instrument and actuated it, is called a *short circuit.* Since the instrument offers some resistance to the flow of current, and a short circuit offers very little, the current will "jump" the instrument and take the easier and shorter path. A short circuit allows the current to flow at such a tremendous speed that high temperatures are generated, and a fire usually results, unless a fuse is provided to automatically open the circuit when an excessive temperature is reached. A melted fuse is said to be *blown.*

*Grounding, hot side, neutral side.* As previously stated, electricity will flow from a higher to a lower potential if offered a conducting path. Theoretically the earth has a potential of zero, and if a current of 110 volts above zero is allowed to contact the earth by means of a good conducting path, the current will flow off into the ground, and the circuit will be *grounded.* A wire which conducts current from the higher level of potential toward an instrument is called by the electrician a *hot line,* or *hot side;* a wire which conducts the current

away from the instrument and toward the lower level of potential is called the *neutral* line or *neutral* side. (Obviously, in alternating current, this distinction is only momentary, as the current is constantly reversing its direction.) Any contact of a circuit with the earth is called a *ground.* If by accident the hot side is allowed to contact with a good conducting path into the earth, the current will "jump" the instrument, as in the case of a short circuit, and flow off into the ground. Likewise, if a person should touch an exposed part of the hot side of a circuit he will ground the current unless he is well insulated from the earth. This is what happens when one gets a "shock." (Since a ground usually offers some resistance to the flow of current, it will not always blow the circuit fuse. If the conducting path constituting the ground offers considerable resistance, it is often very hard to locate easily.)

For dwellings where a small amount of current is needed, power companies usually send only two supply wires into the building, from which all internal circuits are branched off. Where a large amount of current is used, as in theatres, the supply is usually sent in over three wires. The two outside wires each have a potential of 110 volts (or whatever the standard voltage may be) and the center wire is



*neutral.* This system is known as the three-wire Edison system, and is in reality a combination of two two-wire systems; for economy the two neutral wires are combined into one common neutral. With the three-wire system the middle or neutral wire is common to all circuits. To set up a circuit, one side would be connected to either of the outside wires (through a switch and fuse, of course), and the other to the neutral. Where several circuits are in use at the same time, the total load of current must be (as nearly as possible) divided half and half between the two outside wires. This is called *balancing* the load. (If a current of 220 volts were required, which rarely happens, the circuit would be connected to the two outside wires.) In the three-wire system the center or neutral is never fused, because a blown fuse in the neutral would send a current of 220 volts through any two circuits which happened to be connected to opposite sides, and in use at the same time. (See page 69.) The neutral of a three-wire system is ordinarily grounded to the earth; this intentional grounding is done to protect human life and property; it offers an easy conducting path into the ground in cases of serious short circuiting in the wiring. *Since a current of 220 volts is dangerous to human life, it is well to be extremely cautious when working with the three-wire system.*

*Series and parallel circuits.* When two or more pieces of electrical apparatus, such as a row of footlight lamps, are connected together in the same circuit, they may be wired in two different arrangements. If connected end to end to form a continuous loop, so that the current has to flow directly through each individual component to reach the next, the apparatus is said to be connected *in series.* If connected in a column, so that one half the terminals all connect into one side of the circuit, and the other half all connect into the other side, the apparatus is connected *in parallel.* A glance at page 69 will help to clarify the distinction between series and parallel. Apparatus in parallel will have the same voltage supplied to each component part; apparatus in series will have the same amperage in each component, and the voltage will vary. In stage lighting, *lamps used in the same circuit are always connected in parallel; switches, fuses, and dimmers are always connected in series with a circuit.*

### *Light*

*Light* is a form of energy very similar to electricity. Physicists call it *radiant energy visible to the human eye,* and believe that heat, light, and electricity, are all energy of the same kind, differing only in frequency of vibration or *wave length.* At any rate, light travels through free space at the same tremendous speed as electricity, that is, at approximately 186,000 miles per second.

*A light source* is any substance which gives off light rays. The sun is obviously the best known and strongest light source. For stage lighting purposes the most common light source is tungsten wire

when actuated by an electric current. The carbon arc, two sticks of carbon with a gap between them, across which an electric current is allowed to jump, or *arc*, was formerly used considerably as a light source in stage lighting. The carbon arc will produce a very strong light which is whiter than that emitted by tungsten filament, but an arc lamp requires constant attention for necessary adjustment and an expensive iris diaphragm for dimming on and off the light beam. The tungsten lamp does not need constant adjustment once it is set up; the intensity may be controlled from a distance by means of a dimmer. Hence the carbon arc is now seldom used except in large professional productions.

Light visible to the human eye may be either white or colored in various hues. It has been found that white light is really a combination in equal proportions of all the visible hues. By sending a beam of white light through a triangular block of glass, (a prism) it may be broken up into its component hues; this breaking up is called *refraction*, and the band of vari-colored hues is called the *spectrum*. Once white light is refracted into its spectral hues, the individual hues cannot again be broken up; they remain the same color if separately passed through a secondary prism. Experiment has shown that there are seven spectral hues: violet, blue, blue-green, green, yellow, orange and red, and that these hues have differnt *wave-lengths*, violet rays having the shortest, and red rays the longest, frequency.

It is impossible here to go into any discussion of the various color theories. It must suffice to state that the light primaries are not the same as pigment primaries. *Blue, green and red* are the *light primaries*. A discussion of the use of gelatine color media for coloring light and stage use will be made later.

When a substance allows light rays to pass through it, it is said to be *transparent*. A substance which prevents the passage of light rays is called *opaque*. A substance which allows some light rays to pass through, but which will not allow objects to be seen through itself is called *translucent*.

Light passing from one medium to another, such as from air to water, or from air to glass, will be *refracted*, that is, the light rays, except for those which fall absolutely perpendicular to the surface of the second medium, will be slightly bent to one side. When moving in one medium only, however, light rays travel in perfectly straight lines.

When light rays strike an opaque object, the rays are either *reflected* or *absorbed*, depending on the nature of the surface of the opaque object. Some surfaces, such as a highly polished mirror, will reflect most of the rays falling upon it; other surfaces, such as that of a piece of black velvet, will absorb nearly all of the incident rays. No surface is either completely reflecting, and none is completely absorbing.

A stage spotlight, using an incandescent lamp as a light source,

makes use of many of the above principles of light. Its surrounding hood is opaque and prevents the passage of rays where they are undesired. A lens fastened in the front face of the hood is transparent, and permits the passage of light in one desired direction. The lens also refracts all the rays which pass through it into a circular beam of light. A reflector, placed behind the lamp, catches many of the otherwise useless rays and reflects them into the lens, thereby increasing the intensity of the light beam. (See page 78.)

*National Electrical Code; Wiring*

The permanent wiring in a theatre, the flexible temporary wiring (stage cable), and all electric equipment as well, should meet the requirements of the National Electrical Code. The Code is a set of regulations governing lighting installations, with a special section on theatre wiring, prepared by the National Board of Fire Underwriters in New York. The Code has no authority of its own, but most communities have legalized it by municipal ordinance, and insurance companies require strict adherence to it before insuring a building against fire.

Electric wire comes in a great variety of sizes and insulations, and may be either *solid* or *stranded*, the latter being used where flexibility is desired. The current capacity of copper wire is rated according to its cross-sectional diameter; the larger the wire, the greater its capacity in amperes. It is against the Code requirements to use any wire smaller than number 14 (15 ampere capacity) in permanent theatre wiring. It is likewise against the Code to use any size wire to carry a load greater than its safe rated capacity.

TABLE OF WIRE CAPACITIES

BROWN AND SHARPE GAUGE

| *B & S Gauge* | *Max. Capacity* | *B & S Gauge* | *Max. Capacity* |
|---|---|---|---|
| No. 0 | 125 amp. | No. 8 | 35 amp. |
| No. 1 | 100 amp. | No. 10 | 25 amp. |
| No. 2 | 90 amp. | No. 12 | 20 amp. |
| No. 3 | 80 amp. | No. 14 | 15 amp. |
| No. 4 | 70 amp. | No. 16 | 6 amp. |
| No. 5 | 55 amp. | No. 18 | 3 amp. |
| No. 6 | 50 amp. | | |

Electric current is usually brought into a building over large solid copper wires, run in a metal pipe called *conduit*. These main lines terminate in the *main switch panel*, a large metal box which houses the main switch and main fuses, on a slate base for insulation. From

the main switch panel current is redistributed over various wire paths to all circuits in the building. This redistribution is accomplished by means of secondary switch and fuse panels, and by means of the *control board*, commonly called the *switchboard*.

The permanent wiring of the control board is usually done with solid rubber-covered wire, but asbestos-covered wire, either solid or stranded, is often required in wiring that is subjected to heat, as from dimmers. By far the most useful wiring device for the stage electrician is the two-conductor (stranded copper wire) cable known as *stage cable*. Stage cable is extremely flexible, and remarkably tough when subjected to hard usage. It is indispensable for connecting portable or adjustable lighting units to the control board.

### *Control Equipment*

*Switches* are devices used to facilitate the opening or closing of circuits. As mentioned before, a switch is always connected in series with a circuit. The simplest switch is a movable copper bar connected into one side of a circuit, with an insulated operating handle. This is called a *single-pole switch*. It is often advisable, however, to open both sides of a circuit, and for this purpose a *two-pole switch* is used. A two-pole switch will have each copper bar in series with the circuit, but the two bars are connected to one operating handle by means of a non-conducting strip of fibre. In the main switch panel, and elsewhere where three wires must be controlled at once, a *three-pole switch* will be used.

*Fuses* are protective devices inserted in a circuit; they automatically open the circuit when an excessive amperage is reached. Fuses are made in a variety of forms and capacities. For individual circuits, the common *plug fuse* is used; for protecting group circuits and main circuits, various sizes of *cartridge fuses* are ordinarily used, with either *ferrule* or *knife-blade* contacts. The capacities of fuses are always clearly marked thereon, and a circuit should never be fused with a capacity greater than any of its component parts. The load of any circuit should always be carefully checked, and proper fuses placed in the circuit to protect it. Where a load is found not to coincide with available fuse sizes, the available size next above its actual amperage should be used. For instance, with a load of 9.9 amperes, a circuit should be fused with a 10-amp fuse.

A *dimmer* is a device used for raising or lowering the voltage in a circuit. By introducing a variable amount of resistance in series with a circuit a dimmer provides a means for dimming on or off the intensity of a lighting or motor unit. A movable arm, connected to an operating handle, controls the amount of resistance introduced into the circuit. The amount varies from very little, through smoothly graded steps, down to blackout, or resistance enough to render the lighting or motor unit inoperative. *Dimmers must be operated as nearly as possible at their rated load.* A 1000 watt load will soon burn

out a 400 watt dimmer; on the other hand, a 400 watt load on a 1000 watt dimmer will be very little affected by the dimmer, even though the entire resistance be introduced into the circuit. The amperage drawn by 400 watts is so small, comparatively, that the 1000 watt dimmer resistance will not affect it to any great extent. Hence it is necessary to have the proper sized dimmers to effectively control any circuit. It is often impossible to find a dimmer of the exact capacity of the load; a variation of ten percent above or below the rated capacity of the dimmer will be safe and effective.

*Split-pin connectors* are devices used for temporarily connecting two-conductor stage cable to portable units. A connector has two halves which hold together under ordinary strain, but which may be easily pulled apart when changes are necessary. The *female* half of a connector has two brass cylinders into which the brass pins of the *male* half are fastened. The female half should always be connected to the live end of a line, that is, the end leading away from the main supply; the male half should always be connected to the dead end. The reason for this is obvious—if the male half were connected to the live end, and happened to be left exposed, a short circuit might easily occur through contact with a good conductor.

*Color control.* By far the most commonly used color device is *sheet gelatine.* Gelatine may be purchased in a variety of tints from any of the lighting supply houses for around 15 cents a sheet. The average sheet is about 19 by 21 inches in area. Gelatine may be easily cut to any desired size with scissors, and if handled with a fair amount of care it will seldom crack or split until it has performed considerable service. Gelatine sheets are held in place in front of spotlights, floodlights or compartment-type striplights (see later discussion) by means of wooden or metal frames called *slides,* slipped into holding grooves. Gelatine slides may be purchased from standard houses at reasonable prices, the price depending on the size required. One sheet of gelatine will suffice for three or four of the smaller-sized slides. Gelatine shrinks when exposed to heat. It is therefore desirable to allow for this shrinkage when making up slides, especially the larger ones, such as floodlight slides. This may be accomplished by wrinkling the gelatine before trimming it at the edges of the frame. The most useful colors for average theatre use are: Straw and amber, for warm light simulating sunlight or lamplight, daylight blue, for lighting sky drops, deeper blues for night skies, pink, surprise pink, magenta and steel blue for strengthening scenery and make-up color values, red for firelight and medium green for outdoor or cool lighting. A little experience will soon familiarize the theatre worker with the qualities of the standard colors.

Another color device occasionally used is *lamp dip.* Lamp dip is an adhesive dye solution which will cling to the glass bulb of a lamp dipped into it. To dip lamps a small can is ordinarily used; it should be just large enough to allow the lamp to slip down into it without touching the

sides. The can is filled about one-third full of the dip and the lamp dipped into it for a few moments. The lamp should be lighted during or immediately after dipping in order to dry out the dip. Care should be taken not to allow the dip to come up any further than just below the brass screw ring of the lamp. Also, the lamp should not be handled after dipping until the dip is thoroughly dry. Lamp dip may be bought at any of the lighting supply houses. The most useful colors are amber and blue. Lamp dip is used only for lamps of small wattage, up to 60 watts. Its use is virtually restricted to the lamps of open trough footlights and borderlights of small wattage lamps. It is now possible to purchase lamps which have color permanently added to the glass bulb. These are *natural-colored* lamps, and their chief disadvantage is their high cost. They retain their color as long as they last, whereas dipped lamps require frequent redipping.

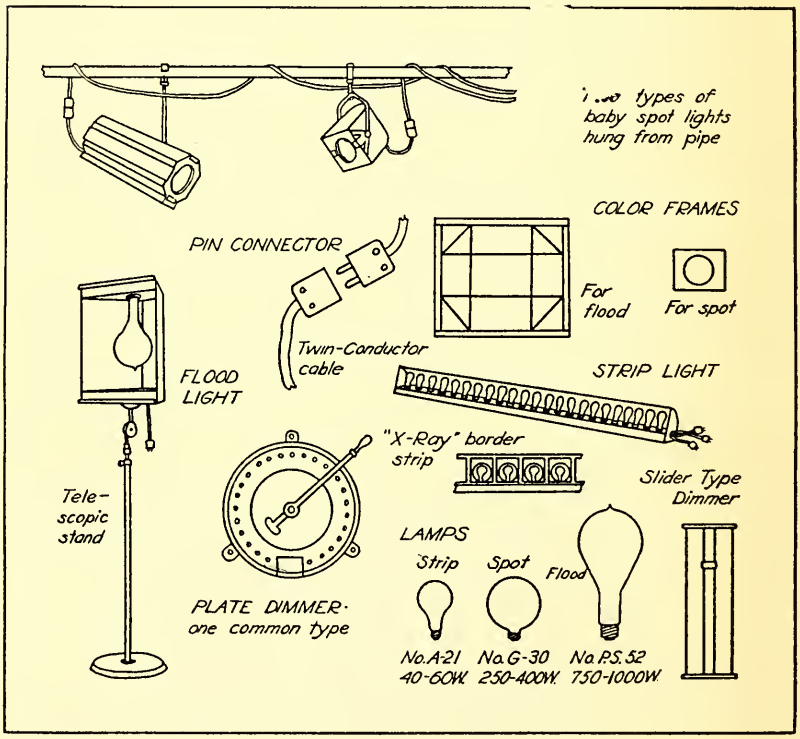
Colored glass slides, and colored glass caps are occasionally used as color media. They are expensive, and their use is thus restricted.

## ORDINARY TYPES OF LIGHTING INSTRUMENTS

In the average non-professional theatre only three main types of lighting instruments will be found in common use. These are, in the order of their intricacy, striplights, floodlights, and spotlights.

It will facilitate discussion of these various units to explain first the various types of lamps and sockets in common use, before passing on to the actual units. A *socket* is a device for supporting the lamp. The *base* of the lamp fits tightly into the socket, and the lamp is thus held rigidly in the desired position. Most lamps and sockets in common use are of the *screw* type, although it is possible to buy the newer *prefocus* type. A prefocus socket, into which the base of the lamp is pushed instead of screwed, has some advantages over the older type. The screw type is still much more common, however. Lamps and sockets come in several sizes, *medium* and *mogul* being the two most common. The candelabra and miniature, respectively smaller than the medium, are seldom used in stage work. The medium screw base is the common type of lamp base in use in the home, and will be therefore most familiar to the beginner. It is about 1 inch in diameter. The mogul base, about 1½ inches in diameter, is used for floodlights and the larger wattage spotlights. Ordinary small wattage lamp,s of various shapes, will already be familiar. These are used in striplights, and should preferably be of the clear glass type, rather than frosted. Floodlights employ a large lamp, of the *pear shaped* (*PS*) type, with a mogul base. Floodlamps may be had in various wattages from 500 to 2000. Floodlamps should be burned base up, although occasionally burning with the base down will not do any great harm. Lamps for spotlight use have a concentrated filament, and come in a variety of watt sizes. Nearly all of those in common use are of the *globular* (G) type, and are labelled G-30, G-40, etc. (The numerals refer to diameter of the bulb in eighths of an inch.) *Spotlight lamps should always be burned base*

*down or horizontal.* If burned base up the heat of the lamp will loosen the socket and shorten the life of the lamp. Spot lamps up to 400 watts are equipped with medium bases; those of 500 watts or more have mogul bases. In purchasing lamps for spotlight use the light-center-length is an important consideration. This is not necessary to specify in spot lamps up to 400 watts, but lamps of 500 watts or more vary considerably in light-center-length. Light-center-length is the distance from the bottom of the lamp to the center of the filament. *The filament of a spot lamp should always be on the principle axis of the spotlight lens;* that is, on a line projected through the center of the lens from front to back. (By sighting directly into the front face of the lens, the accuracy of this adjustment may be tested, if the lamp is exposed to strong light by raising the operating door of the housing.) Most large spotlights with mogul sockets have an adjustment which allows the use of various light-center-length lamps, but this adjustment is troublesome and awkward to make. It is much better to eliminate the difficulty by adhering to a standard size, and purchasing replacement lamps accordingly. (See page 78.)



*Striplights*

In the class of striplights are included all lighting units which employ rows of small wattage lamps. Hence striplights would include footlights, borderlights, and the smaller strips used to light behind doorways, etc. *Footlights* may be of two general types: *open trough* and *compartment.* The open trough type is the most common; in it the lamps are housed in a straight trough, with a curved hood which passes up over the back of the strip and partially masks the undesired light. The great disadvantage of open trough footlights is the inflexibility; they are bound to spill a great deal of undesired light over the upper and side edges of the proscenium wall, and they are difficult to color effectively. Lamp dip is the only color control method, and a great deal of its value is lost when two or more colors are used together. An infinitely more satisfactory footlight is the compartment type. It is of course much more expensive, but the convenience is worth the expense. The compartment type allows the use of gelatine slides for controlling color; it also controls most of the light spill. Each lamp is housed in a separate compartment, and the gelatine slide may be easily and quickly changed. Footlights are usually built in standard lengths, though special lengths can be purchased from supply houses. It is customary to wire footlights in three separate circuits, to aid in controlling color and intensity. *Borderlights* are very similar in construction to footlights, the main difference being in position. Borderlights are hung from overhead, usually just behind the front curtain. Occasionally a second or third border strip will be hung at from six to ten foot intervals back of the first border. Second and third border lights, however, are somewhat old-fashioned, and are seldom needed except on very deep stages. *Striplights, or strips,* are short rows of lamps used for lighting up stage entrances, the bottom edge of sky drops, etc. They are generally of the open type, and ordinarily are wired in only one circuit. They may be bought in almost any desired length.

*Floodlights*

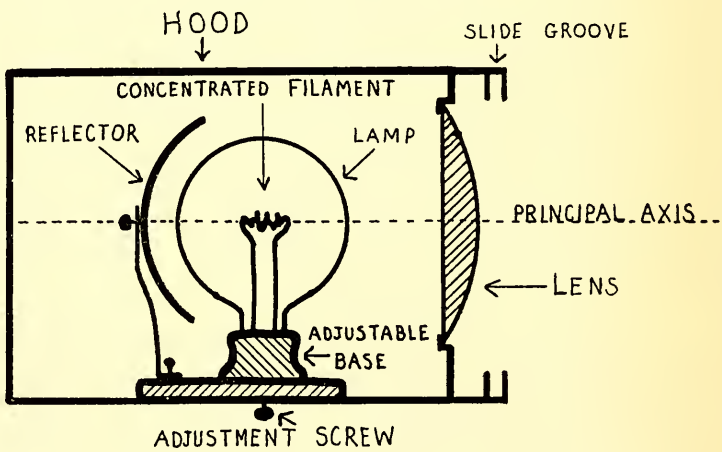
Floodlights are simple hood units designed to use a large lamp, and to throw a strong sheet of light. They are generally employed to light sky drops or cyloramas, for throwing a strong flood of light through windows or other stage setting openings, and occasionally in smaller wattages as borderlights. If used for borderlights they usually are manufactured in strips of six or more, with three-circuit control. Floodlights for overhead use may be hung with either a clamp arm or with chains. They are ordinarily swung on a pipe batten, and the clamp support is more comfortable to handle. For floor use a metal stand is usually employed. Floodlights are equipped with metal grooves for supporting wooden gelatine color slides.

*Spotlights*

Striplights and floodlights are designed to throw a diffused general

light. *Spotlights* are units designed to concentrate light on a restricted area. They are equipped with a surrounding housing called the *hood*, in the face of which is fastened a *plano-convex lens*. The lens gathers up the rays which strike it and condense them into a circular *beam* of light. The light beam may be partially controlled in spread by adjusting the lamp socket. The socket is held in position by an adjustment screw, which allows the operator to move the lamp toward or away from the lens as desired, within certain limits. The lamp is at maximum efficiency (theoretically) when the filament is at the focus of the lens. This focus is usually at or near the back of the adjustment slide. Most spotlights are equipped with metal or glass reflectors, which gather up the light rays thrown into them and redirect them toward the lens, thus increasing the light output. Spotlights are equipped with grooves for holding gelatine color slides. Expensive types have soft-edge devices for softening the circumference of the light beam.

The most useful types of spotlight for amateur use are the 400 watt "baby" type, and the larger 1000 watt type. The 400 watt baby spot will be found very satisfactory for lighting at a short distance, or *throw*. For long throw, as from a balcony or light booth, the 1000



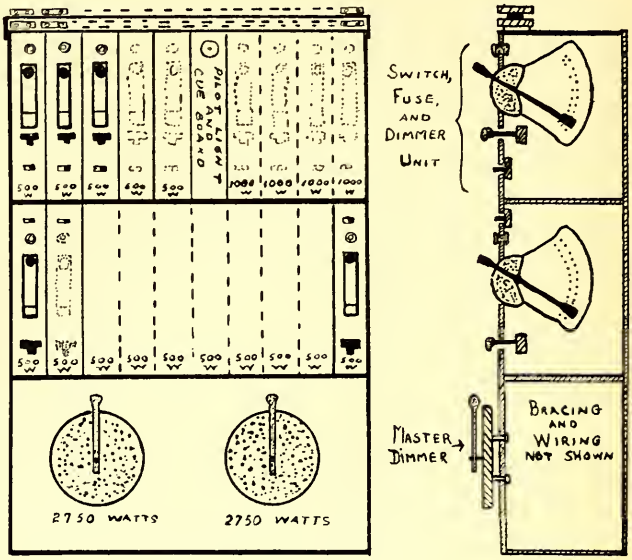

DIAGRAMMATIC CROSS-SECTION OF A SPOTLIGHT

watt or larger is generally needed. In purchasing a spotlight the distance of throw and the maximum diameter of the spot area should be specified. It is well to have a standard type of spotlight, in each size, and to purchase all additions in the same type. This will aid in flexibility in handling, by permitting quick interchangability.

### *A Typical Lighting Lay-Out*

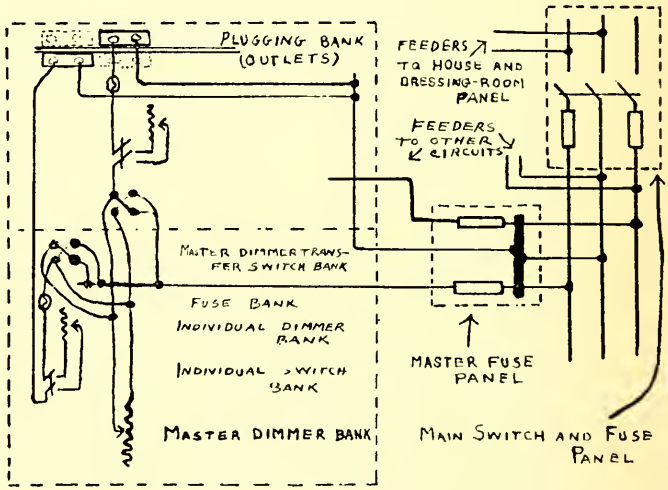
In order briefly to describe a workable lighting lay-out for the average non-professional theatre, the Carolina Playmakers Theatre equipment has been chosen as an example. The set-up allows for great flexibility of control, and is entirely adequate for practically any size production. Close reference to the accompanying diagram will facilitate understanding.

The current is brought into the building over a standard three-wire Edison system, the neutral wire and the control board frame being grounded to the radiator system for protection. From the main switch panel branch-off lines to supply the front of the building and the dressing-rooms are carried to a special panel. The three main lines are carried directly into a fuse panel, where the four separate divisions of the control board are properly fused. From this point the neutral line branches out directly into one side of each of the connectors located in the *plugging panel* above the *control board.* The two outside, or hot lines are branched to the switch-fuse-and-dimmer units, half of the latter being supplied by one side, and half by the other side. From the switch-and-dimmer units each circuit connects into one side of a connector in the plugging panel. Lines to the footlights and borderlights (compartment type), and to the sky floodlights are first run as far as possible in metal conduit, to *secondary outlets.* From these outlets to the actual units No. 14 stage cable is employed. Lines to the beam spotlights (4 1000-watt units) are also run in conduit. The six teaser spotlights, and the six tormentor spotlights are of the Pevear soft-edge type, 400-watt size. They connect into the plugging panel directly by No. 14 stage cable, the cables being run in common bundles held together by friction tape. Each connector, (except the male half connected directly to the leads of the instrument itself), is lettered for identification. Thus it is possible, at the plugging panel, to plug in any unit into any switch-and-dimmer unit. An auxiliary switchboard of the Dimmerette type, with 12 outlets (every 2 outlets being controlled by one variable wattage dimmer) is provided for additional circuits when needed. Incidentally, the auxiliary switchboard is easily detachable, and is used as a portable control board in outdoor and touring productions. Six wall outlets are also provided for using stand units on the floor. An even greater flexibility is gained by using a multiple connector on the white circuit of both the footlights and borderlights. With the multiple connector one, two or three of the circuits can be connected to one line as desired.




DIAGRAMMATIC FRONT AND SIDE VIEWS

CONTROL BOARD – PLAYMAKERS THEATRE




WIRING DIAGRAM

The footlights are used primarily to remove undesired shadows caused by the overhead units. The borderlights are used for general diffused lighting, for visibility, and general color lighting. The tormentor and teaser spots are used for specific lighting; that is, for lighting the important acting areas, for brightening up entrances and other features of the stage setting, and for strengthening color values. The front beam spots are used primarily to light up the downstage portion of the stage and also to spot announcers before the curtain. Four 1000 watt floodlights are hung on a pipe batten just in front of the sky drop, providing ample light for two different colors of sky without making gelatine changes. Several extra units, including spots, floods and strips, are used for additional light wherever required. Color control is easily achieved, since a standard size of slide fits practically all of the spot units, another standard size fits all floodlight units. Quick interchangeability is achieved by equipping each unit with a standard, 15 ampere connector, and by having already made up several different lengths of cable with the same connector size.

PART VIII

# MAKE-UP

ORA MAE DAVIS

The object of make-up is to intensify the natural facial expression so that it will be effective when seen from a distance, or to change the facial character of a player into something entirely different from himself. Make-up must be used to make the face appear natural under the stage lighting, which changes the tones of the face and casts shadows.

Make-up is one of the most fascinating and difficult arts connected with the theatre, but one which can be learned by almost anyone sufficiently interested to spend time and patience on its study. The rudimentary rules that can be written down here are very few, and make-up cannot really be learned from a book. Practice is the only way.

The beginning artist should study faces very carefully—making mental notes of lines, wrinkles, shadows and beards. He should try to figure out for himself what facial markings make a certain person look sad, sick, mean or worried, or another, cheerful, dissipated, greedy or dumb. Besides studying the faces of persons in real life, the artist must study the character of the person in the play, and the face of the actor playing the part. Frown lines, wrinkles and shadows must go where they would naturally grow on the actor's face. A make-up is not a mask which can change the entire face. Natural good points should be brought out and defects covered up as well as possible.

Make-ups should be put on before a bright light and then tried out under the lights on the stage. A make-up which appears a masterpiece in the dressing room may change into something entirely different under the various colors and angles of the stage lights.

## METHOD

Make-up should be applied before the final details of dressing are completed so as to avoid spoiling the costume. A piece of cheese cloth or a soft towel should be tied around the head to hold the hair back out of the way, and one around the shoulders to protect the costume.

The first step is to apply cold cream all over the face and neck; everywhere where make-up is to be used. Then wipe off all the cold cream, leaving the surface very *slightly* greasy. The amount of cold cream to leave on the face can be learned only by practice; if too much is left, the make-up will always be greasy and shiny, if too little, the grease paint will not blend properly, and will be difficult to remove.

Foundation grease paint is the next step, and should be blended on the face lightly with the tips of the fingers. The most important

point in this step is that the grease paint should be smoothed *on* the face and not *into* the skin. A great many beginners think it necessary to rub very hard, and they only succeed in rubbing off the grease paint in spots and leave a very uneven surface. Be sure that the make-up is blended well around the edges of the hair, back of the neck, under the chin and down as far as the costume will show the skin.

If a straight make-up is being used (that is, if the actor is about the same age and position as the character to be portrayed) the next step is to blend in a little lining color over the eyes. For brown eyes a brown shadow is usually best and for blue eyes, a blue shadow. The color should be heaviest next to the eye lids and blend out entirely just before reaching the eyebrows.

Moist rouge should be applied next and blended very carefully. Starting from the cheek bone just below the temple, blend gently outwards toward the nose and down slightly. Be careful not to have the rouge placed too low toward the front or it will give the appearance of hollow cheeks instead of rouge. Rouge for men should be worked in higher up toward the temples and in to the edge of the eye lid. Be sure to blend a man's rouge very carefully so that the audience will not suspect that he has on any at all.

Next, outline the eyes with a tooth pick stuck into the brown liner and smoothed off on the hand so that there are not any dabs of grease paint on the tooth pick to make a heavy spot. Begin the line about a quarter of an inch from the nose, draw it as close to the eyelash as possible and extend it about a quarter of an inch beyond the eye. Repeat for the upper lid, drawing the two lines together at the outer edge of the eye. If the character needs to have a mean, greedy look, the outline should be drawn all around the eye, very close, and stopped right at the outer edge of the eye. These lines should be blended slightly with the finger if they seem hard. Black should never be used for outlining the eyes or for wrinkles. For a juvenile make-up a tiny spot of vermillion at the inner corner of each eye, next to the nose, is sometimes used to add to their brilliance.

The eyebrows are drawn on in the desired shape, using a toothpick. Use brown in most cases unless the actor has very black hair. Men with very heavy natural eyebrows do not need any painted on, or the brows will look too heavy for the face. The shape of the eyebrows may be changed by painting them over heavily with the foundation grease paint, powdering them well, and then painting on new ones the desired shape.

Next powder profusely over the entire make-up. Fill the puff very full of powder several times and pat it gently over the surface, then brush it off with a soft baby brush. Do not try to rub on powder as it is put on for street make-up or it will surely mar the

make-up. Heavy powdering is very important. It keeps the make-up from looking greasy from the audience, and prevents it from coming off on the costume. The lips should be painted next. Purse them gently and apply color to each curve of the Cupid's bow on the upper lip and in the center of the lower lip. Blend this color to the corners of the mouth. Do not let the line of the lips seem hard. If the lower lip is too full it may be blocked out with grease paint and painted in the desired shape. Or the lips may be enlarged if too thin.

Now examine the make-up and if the rouge needs to be touched up, do it with dry rouge on a rabbit's foot or a soft powder puff. The eyebrows and lashes may also be retouched if the powdering has dulled them considerably.

The colors of grease paint and rouge must be darker of course for young men than for young women, but the method is the same; just be sure that the man does not look made-up. Each step in these directions has its special reason for being done in the order suggested. If the eyes are outlined before the rouge and eye shadow is put on, then the rouge and shadow cannot be blended without blurring the lines. If the powder is put on before the lines and shadows, then they will be much too harsh. It is best to put on all the make-up, except lip rouge, powder heavily, and then touch up the lines and shadows very lightly if necessary.

If a great many juvenile make-ups are to be used in a small auditorium where the lights are not very strong, it is simpler to leave off the grease paint foundation and do the rest of the make-up as suggested.

## CHARACTER MAKE-UPS

For character make-up the beginning steps are just the same as for a straight make-up. After the foundation color has been blended smoothly over the face, neck, ears, hands and arms—wherever the skin will show—appropriate shadows and lines are next applied with a tooth pick and blended with the fingers. A mixture of gray and red gives the best effect for shadows. For very old characters the eyes should be sunk into their sockets by blending the shadow completely around them. The color should be deepest next the nose. The eyes may be given a dull expression by drawing a fine white line around the edges of the lids next to the eye lashes. Have the actor suck in his cheeks and you will find the proper place to blend in the triangular cheek shadows. A heavy line from the base of the nose to the edge of the mouth should be brought out to form one side of this triangle. Every actor's face is shaped differently and it is best to study each individual and put lines and shadows where they would naturally grow on that person's face. Have the actor wrinkle his forehead and draw in the lines where they are already beginning to form. If the actor does not have frown lines between the eyes and his character needs them, they can be painted on. If

the character to be portrayed is hale and hearty, brown or dark red should be used for the wrinkle lines—if very old and feeble, gray is a better color. All of the wrinkles must be blended into a smooth soft line with the tip of the finger. The outer edge of the lines should be blended so subtly that you cannot tell exactly where they end. There is a definite "touch" for blending in lines and shadows properly, and that can only be acquired with practice. All of these wrinkles and shadows should have a highlight of yellow or white drawn at the top of the dark line and blended very smoothly into the foundation. Every wrinkle or furrow has a light line as well as a shadow, and if these are left off the wrinkles and shadows will look painted on and very unnatural. The cheek bones may be made prominent by a highlight, or the forehead or chin, as the character indicates.

Be sure to make up the neck, ears, arms and hands to correspond with the face. A very old and wrinkled face above a smooth, young neck and white hands with long beautifully polished finger nails is a very incongruous picture. A heavy shadow should go around the neck just under the jaw bone, and shadows down each side of the throat. A highlight on the Adam's apple is sometimes a good effect and a shadow just at the base of the neck.

For old and rough characters a good effect may be obtained by using a light gray or brown liner and rubbing it over the eyebrows in the wrong direction. This gives a bushy and ragged look to the eyebrows. The mouth for an old character should never have any rouge. The lips may be made to look shriveled by drawing fine brown lines on each lip, beginning just inside the mouth and blending out entirely just an eighth of an inch outside the line of the lips. The lower lip will droop if a shadow is worked in directly under it.

An effect of blindness can be secured by attaching a narrow strip of adhesive tape to the upper and lower eyelids, directly over the pupil, and then painting the two ends with grease paint the same color as the face, leaving the center portion over the eye, white. The eye can be left open and the actor can see out around the edge of the tape.

Nose putty is a very useful material for building up and changing the shape of the face, the nose in particular. It should be kneaded carefully in the finger tips and molded onto the face in the desired shape. Then the foundation grease paint can be applied over it the same as the rest of the face.

Teeth can be blocked out with black wax to be obtained in all lines of make-up, or if the character is on for a very short while, a piece of black grease paint can be used.

To give a young person gray hair, ordinary corn starch is better than white powder. It looks more natural and is much easier to remove. Most of it can be brushed out.

## BEARDS

The proper beard or moustache can give the complete expression of a character more than any other detail of the make-up. Beards are very plastic as make-up material and wonderful changes can be accomplished with them. But they must be life-like. Crepe hair must be used, never a ready-made beard. Crepe hair comes in long braided strands. The strings wrapping it should be removed and the hair fluffed out into a sort of thin mat. If prepared the night before, the hair may be moistened and stretched so that the kink will disappear entirely. If this is not done the kink should be pulled out gently with the fingers. When fluffed out the hair may be cut in approximately the desired shape, by laying it against the face and estimating the amount needed.

Spirit gum is used to stick the hair to the face, and there is no good substitute. Beards should be applied after all the rest of the make-up has been done. Remove the make-up just at the place where the beard is to be attached, or else do not apply any there in the first place. Otherwise the spirit gum will not hold very securely. Brush the spirit gum over the surface where the beard is to go, then lay the crepe hair on lightly. Press a cloth over the crepe hair and hold it firmly in place with the flat of the hand for several minutes until the spirit gum has had time to dry.

Short stubby beards can be easily made with the hair fluffed into a light mat. Stick it over the surface to be covered and then trim to the desired shape and length with the scissors. Long beards and special types should be carefully shaped with the fingers before sticking on the face, and then trimmed to perfection after they are stuck on. It is much easier to put on most beards and moustaches in several sections. Be sure to take the beard up to meet the hair line at the temples if a full face beard is wanted. And don't forget also that hair grows under the chin and down onto the neck. Always try to have the strands of the hair pointing in the same direction as the natural beard grows, and the top line of the beard on the face must not go beyond the line where the beard grows naturally.

Spirit gum may have an unpleasant odor for some people but it will not hurt anyone or damage the skin, and the odor will very soon disappear. To remove the beard it should first be pulled off with the fingers and the remainder removed with alcohol or cold cream.

## MATERIALS

For a moderately large make-up box the following materials are necessary:

1. Cold Cream, bought at about $.60 for a half-pound can. Used to protect the skin and also to remove make-up.
2. Cheese-cloth, cut in squares, or clean, soft white cotton rags. Used to wipe off cold cream and make-up.
3. Grease Paint, sold in large sticks for about $.35, used for foundation tones. The most valuable colors are:

Light Flesh Pink,
Natural or Juvenile,
Dark Sunburn,
Healthy Middle Age,
Sallow Old Age,
Olive,
Brown (for Negro Make-up).

Light Flesh Pink with a little rouge, carmine or vermillion added, will make other darker shades, or it may be toned down with white. Dark Sunburn, put on very sparingly, or toned with flesh, may take the place of Light Sunburn. Special colors such as Chinese, Gypsy, Mulatto (or "Othello"), Indian, etc., may be needed. Such shades as Sallow Young Man, Robust Old Age, and the varying tones of Flesh and Juvenile are useful but not absolutely necessary for the small box. They may be easily mixed.

4. **Liners**, small sticks of grease paint in dark colors, sold for about $.25 apiece, used for making shadows and lines, for touching up the eyes, and for making high lights. The shades most used are:

White (for high lights),
Dark Grey,
Light Grey,
Dark Brown,
Dark Crimson,
Light Carmine,
Vermillion,
Yellow (for high lights),
Medium Blue.

A mixture of grey and crimson is the best lining shade as it blends with the ground tone and makes a neutral shadow. Other tints may also be mixed. The blues are especially useful for lining the eyes in straight make-up.

5. **Powders**, sold in $.60 half-pound cans, keep the face from shining and blend the whole make-up. The most necessary are:

White,
Flesh Pink,
Deep Sunburn,
Healthy Middle Age,
Sallow Old Age,

These powders form the base for many tones, obtained by mixing. Special shades may be required—Indian, Mulatto, (or "Othello"), Olive, Chinese, etc.

6. Dry Rouge, sold in boxes at about $.30.

Brilliant (for blondes),
Medium dark (for brunettes).

7. **Moist Rouge.** A good rouge for men is Stein's Moist Rouge, sold for $.50 a can. It must be used very sparingly. The crimson, carmine and vermillion Liners may be used as rouge and lipstick for women in most cases.

8. **Spirit Gum**, sold for about $.35 a bottle. Used to attach crepe hair for beards, eyebrows, and moustaches.

9. **Crepe Hair** is sold by the foot. The most useful shades are: dark brown, dark grey, medium grey, and light grey. Blond, black, and red may sometimes be needed.

10. **Lining Pencils** in different colors are made by many of the make-up houses and sell for about $.50 apiece, but tooth picks stuck into the grease paint are just as effective and much less expensive.
11. **Powder Puffs.** It is a good thing to keep those for each color separate.
12. **Rabbit's Feet** should be used for applying dry rouge.
13. **Nose Putty** for modeling noses, and
14. **Black Wax** for blocking out teeth for character work will sometimes be needed.

Two of the most reliable make-up firms are: The M. Stein Cosmetic Company, 51 Madison Avenue, New York, and Max Factor's Make-up Studios, Highland at Hollywood Boulevard, Hollywood, California. Both will be glad to send upon request complete catalogs and price lists of their materials, and they also publish instruction booklets and charts which will serve excellently as practice lessons for the beginner.

## AFTERTHOUGHTS

### I. CAROLINA FOLK-PLAYS

*FOUR VOLUMES*

*Carolina Folk-Plays, First, Second* and *Third Series,* published by Henry Holt and Company, and *Carolina Folk Comedies,* published by Samuel French, Inc. The plays are edited with introductions by Frederick H. Koch, founder and director of The Carolina Playmakers.

These volumes offer a wide range—from the Great Smoky Mountains on the western border of the Carolina country to the treacherous shoals of Hatteras. Here are plays of heroic highland people, strange of tales of folk superstition, the struggling lives of work-worn tenant farmers, romances of plantation days, class conflict in mill villages—a colorful variety of folk comedy and tragedy to folk imagination and beauty. Most of them have simple settings and they are not difficult to produce. They have been staged with much success all over the country.

All four books are illustrated with photographs of the original productions of the plays in Chapel Hill and with interesting scenes of The Playmakers in their workshop and on tour.

Two outdoor productions by The Carolina Playmakers. *Alcestis,* in the Stadium. Directed by Harry E. Davis, with a setting by Mary Dirnberger and chorus movements by Phoebe Barr. *Hamlet* in The Forest Theatre, with Professor Koch in the title role. Directed and designed by Samuel Selden. Costumes for both plays by Ora Mae Davis. Lighting by Harry Davis.

The première of *Shroud My Body Down*, a Folk Dream, by Paul Green. Directed by Samuel Selden, with settings by Samuel Selden and Wilbur Dorsett and lighting by Harry Davis. The use of rolling platforms made possible 30-second scene-shifts. Produced on December 7 and 8, 1934, by The Carolina Playmakers in their theatre in Chapel Hill.

## II. EXTENSION LIBRARY SERVICE

Through the loan service of the University Extension Library, many books concerning the theatre and hundreds of plays are available.

For a fee of twenty-five cents (.25) any one may borrow for three weeks as many as three books (or twelve plays) at one time.

For a fee of one dollar ($1.00) any group or individual may borrow for three months as many as twenty books.

For a fee of three dollars ($3.00) any group or individual may borrow for six months as many as forty books.

Postage in all cases is borne by the borrower. The rate for packages to any point in North Carolina is ten cents (.10) per package of not more than three books.

A book or package of books may be renewed for one week for a fee of ten cents (.10).

The following bulletins, treating on some phase of theatre art, may be secured by addressing the University Extension Division:

Vol. IV No. 5 A STUDY COURSE IN AMERICAN ONE ACT PLAYS, by Ethel T. Rockwell.

Vol. IV No. 12 CHILDREN OF OLD CAROLINA, by Ethel T. Rockwell.

Vol. VI No. 3 A STUDY COURSE IN INTERNATIONAL ONE ACT PLAYS, by Ethel T. Rockwell.

Vol. VI No. 9 A STUDY COURSE IN MODERN DRAMA, by Elizabeth Lay.

Vol. VIII No. 7 SCENERY AND LIGHTING FOR SCHOOL AND LITTLE THEATRE STAGES, by Samuel Selden.

Vol. IX No. 3 A STUDY COURSE IN AMERICAN ONE ACT PLAYS, by Ethel T. Rockwell.

Vol. IX No. 8 PLAYS FOR SCHOOLS AND LITTLE THEATRES, by Frederick H. Koch and Nettina Strobach.

A charge of fifty cents (.50) is made for each of these bulletins. A remittance should accompany each order.

## III. DEALERS IN STAGE EQUIPMENT

### General Equipment

Abbott Scrim Profile Company, 266 West 44th Street, New York, N. Y. (Theatrical Hardware and Supplies.)

Art Craft Theatre Equipment Company, 108 West 46th Street, New York, N. Y. (General Stage Eqiupment. Dealers in the Dimmerette Switchboard.)

Cleon Throckmorton, Inc., 102 West Third Street, New York, N. Y. General Stage Equipment. One of the best. Installation engineers.)

Vallen Electrical Company, Akron, Ohio. (Curtain tracks and rigging.)

### Scene Paints

Abraham Brothers, 38 West 28th Street, New York, N. Y. (Paint Supplies.)

Aljo Manufacturing Company, 130 West 21st Street, New York, N. Y. (Paint Supplies.)

Cleon Throckmorton, Inc., 102 West Third Street, New York, N. Y. (Dealers in Paint Supplies.)

### Costume Houses

Brooks Costume Rental Company, 260 West 41st Street, New York, N. Y. (Costumers.)

Hooker Howe Costume Company, 46-52 South Main Street, Haverhill, Mass. (Costumers.)

Waas and Son, 123 South Eleventh Street, Philadelphia, Pa. (Costumers, and Dealers in Fabrics.)

Dazian's, Inc., 142 West 44th Street, New York, N. Y. (Costume Fabrics, Trimmings, Etc.)

Wolff, Fording and Company, 46 Stuart Street, Boston, Mass. (Costume Materials and Trimmings.)

### Make-up and Wigs

Max Factor's Make-up Studios, Highland Avenue at Hollywood, Los Angeles, California. (Make-up Supplies.)

M. Stein Cosmetic Company, 51 Madison Avenue, New York, N. Y. (Make-up Supplies.)

Alex Marks, 662 8th Street, New York, N. Y. (Wigs.)

Oscar F. Bernner, 107 West 46th Street, New York, N. Y. (Wigs.)

### Lighting Equipment and Supplies

Century Lighting Equipment Company, 419 West 55th Street, New York, N. Y. (General Lighting Equipment.)

Kliegl Brothers, 321 West 50th Street, New York, N. Y. (General Lighting Equipment.)

Rosco Laboratories, 367 Hudson Avenue, Brooklyn, N. Y. (Gelatine media.)

Stroblite Company, 35 West 52nd Street, New York, N. Y. (Luminous paints and supplies.)

### Properties

William Bradley Studios, 318 West 43rd Street, New York, N. Y. (Properties for sale or rental.)

### Special Effect Phonograph Records

Gennett Records, Thomas J. Valentino, 729 Seventh Aevenue, New York, N. Y. (Effect phonograph records.)

# THE UNIVERSITY OF NORTH CAROLINA
# EXTENSION BULLETIN

## ADVENTURES IN READING SERIES

*Current Books of 1923-1924.* C. S. Love. 1924.
*Current Books for 1924-1925.* C. S. Love. 1925.
*Current Books for 1925-1926.* C. S. Love. 1926.
*Current Books for 1926-1927.* Russell Potter. 1927.
*Current Books for 1928-1929.* Russell Potter. 1929.
*Current Books for 1929-1930.* M. N. and R. P. Bond. 1930.
*Current Books for 1930-1931.* M. N. and R. P. Bond. 1931.
*Current Books for 1931-1932.* M. N. Bond. 1933.
*Current Books for 1933.* M. N. Bond. 1934.

## LITERATURE: SOUTHERN, AMERICAN, FOREIGN

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CHAPEL HILL, NORTH CAROLINA

UNIVERSITY OF NORTH CAROLINA
EXTENSION BULLETIN

VOL. XV SEPTEMBER, 1935 NO. 2

# SOCIALIZATION OF MEDICINE

*Compiled by*
E. R. RANKIN

*Debate Handbook*

CHAPEL HILL MCMXXXV
THE UNIVERSITY OF NORTH CAROLINA PRESS

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# THE HIGH SCHOOL DEBATING UNION

## REVIEW OF CONTESTS HELD

The High School Debating Union was organized among the high schools of North Carolina by the Dialectic and Philanthropic literary societies of the University of North Carolina during the school year 1912-13. The query of that year was, RESOLVED, *That the constitution of North Carolina should be so amended as to allow women to vote under the same qualifications as men.* Ninety schools participated in the first annual state-wide debate, which was held on February 22, 1913. Sixteen schools won both debates and sent their teams to Chapel Hill for the final contest. The Pleasant Garden high school, represented by Grady Bowman and S. C. Hodgin, on the affirmative, won the Aycock Memorial Cup in the final debate on March 7, 1913.

One hundred and fifty high schools took part in the second annual state-wide debate on March 20, 1914, on the subject, RESOLVED, *That the constitution of North Carolina should be so amended as to allow the initiative and referendum in state-wide legislation.* Forty-one schools won both of their debates and sent their teams to Chapel Hill for the final contest. The Winston-Salem high school, represented by Charles Roddick and Clifton Eaton, on the negative, won the Aycock Memorial Cup in the final debate on April 3, 1914. During the school year 1913-14 the High School Debating Union was incorporated as a regular feature of the work of the University Extension Division.

Two hundred and fifty schools took part in the third annual state-wide contest on March 26, 1915, on the query, RESOLVED, *That the United States should adopt the policy of subsidizing its merchant marine engaged in foreign trade.* Fifty schools won both debates and sent their teams to Chapel Hill for the final contest. The Wilson high school, represented by Misses Lalla Rookh Fleming and Ethel Gardner, on the negative, won the Aycock Memorial Cup in the final debate on April 9, 1915.

The query which was discussed in the fourth annual contest, which was held on March 31, 1916, was, RESOLVED, *That the United States should adopt the policy of greatly enlarging its navy.* Three hundred and twenty-five schools enrolled for the state-wide debate. Sixty-eight schools won both of their debates and sent their speakers to Chapel Hill for the final contest. Miss Myrtle Cooper and Boyd Harden, speakers on the affirmative for the Graham high school, won the Aycock Memorial Cup in the final debate on April 14, 1916.

Three hundred and thirty-one schools participated in the fifth annual state-wide debate, which was held on March 31, 1917, on the query, RESOLVED, *That the federal government should own and operate the railways.* Seventy-four schools won both of their debates and sent their debaters to Chapel Hill for the final contest. The Waynesville high school, represented by Vinson Smathers and Roy Francis, on the affirmative, won the Aycock Memorial Cup in the final debate on April 20, 1917.

The sixth annual contest centered around the query, RESOLVED, *That Congress should enact a law providing for the compulsory arbitration of industrial disputes.* Three hundred schools participated in the triangular debates on March 29, 1918. Sixty-six schools won both debates and sent their teams to Chapel Hill to enter the final contest. Thomas Burton and Will Anderson, representing the Wilson high school, on the negative, won the Aycock Memorial Cup in the final debate on April 12, 1918.

One hundred and eighty schools enrolled for the seventh annual state-wide debate on April 4, 1919, on the query, RESOLVED, *That the United States government should adopt a policy requiring one year of military training for all able-bodied men before they reach the age of 21.* Forty-one schools won both of their debates and sent their teams to the University for the final contest. The Durham high school, represented by Miss Aura Holton and Leo Brady, on the negative, won the Aycock Memorial Cup in the final debate on May 2, 1919.

Two hundred schools participated on April 14, 1920, in the eighth annual state-wide debate on the query, RESOLVED, *That the United States should adopt a policy of further material restriction of immigration.* Forty-four schools won both of their debates and sent their teams to the University to take part in the final contest. The Asheville high school, represented by Arthur Kale and Clifton Ervin, on the affirmative, won the Aycock Memorial Cup in the final debate on April 28, 1920.

Two hundred high schools participated in the ninth annual state-wide debating contest. The query was, RESOLVED, *That the policy of collective bargaining through trade unions should prevail in American industry.* Fifty schools won both of their debates in the triangular contest on April 1, 1921, and sent their teams to the University for the final contest. Miss Eunice Hutchins and Ludlow Rogers, of the Durham high school, representing the negative, won the Aycock Memorial Cup in the final debate on April 15, 1921.

Two hundred and fifty schools took part in the tenth annual state-wide debate on March 24, 1922, on the query, RESOLVED, *That the United States should enter the League of Nations.* Sixty schools won both of their debates and sent their teams to Chapel Hill for the final contest. The Durham high school, represented by Linwood Hollowell and Freeman Twaddell, on the negative, won the Aycock Memorial Cup in the final debate on April 7, 1922.

Two hundred and fifty schools participated in the eleventh annual state-wide debate on March 31, 1923, on the query, RESOLVED, *That Congress should provide for the enforcement of decisions of the Railroad Labor Board.* Sixty schools won both of their debates and sent their teams to the University for the final contest. The Elizabeth City high school, represented by Misses Ellen Mellick and Mary Dozier, on the negative, won the Aycock Memorial Cup in the final debate on April 13, 1923.

Two hundred and fifty schools took part in the twelfth annual state-wide debate on March 28, 1924, on the query, RESOLVED, *That the inter-*

*allied war debts should be cancelled.* Seventy-one schools won both of their debates and sent their teams to the University for the final contest. The Wilson high school, represented by Miss Catherine Ware and Fred Carr, on the affirmative, won the Aycock Memorial Cup in the final debate on April 11, 1924.

Two hundred and thirty-five schools entered the thirteenth annual state-wide contest on March 27, 1925. The query was, RESOLVED, *That North Carolina should ratify the port terminals and water transportation act.* Sixty-five schools won both of their debates and sent their teams to Chapel Hill for the final contest. Miss Catherine Ware and Fred Carr, of the Wilson high school, representing the negative, won the Aycock Memorial Cup in the final debate on April 10, 1925.

Two hundred and twenty-four schools took part in the fourteenth annual state-wide debate on April 2, 1926, on the query, RESOLVED, *That North Carolina should levy a state tax on property to aid in the support of an eight months school term.* Sixty-seven schools won both of their debates and sent their teams to the University for the final contest. The Winston-Salem high school, represented by Misses Mell Efird and Loretto Carroll, on the negative, won the Aycock Memorial Cup in the final debate on April 16, 1926.

Two hundred and twenty-three schools participated in the fifteenth annual state-wide debate on April 1, 1927, on the query, RESOLVED, *That Congress should enact the Curtis-Reed bill, providing for a federal department of education.* Sixty-seven schools won both of their debates and sent their teams to the University. Harry Gump and Henry Biggs, of the Greensboro high school, representing the affirmative, won the Aycock Memorial Cup in the final debate on April 15, 1927.

One hundred and ninety-five schools entered the sixteenth annual state-wide debate which was held on April 6, 1928. The query for that year was, RESOLVED, *That Congress should enact the McNary-Haugen farm relief bill.* Fifty schools won both of their debates and sent their representatives to the University. The Washington Collegiate Institute, represented by Henry Roper and Hal Hopper, on the negative, won the Aycock Memorial Cup in the final debate on April 20, 1928.

One hundred and ninety-six schools participated in the seventeenth annual state-wide contest on April 5, 1929, on the query, RESOLVED, *That the United States should join the World Court.* Fifty-nine schools won both of their debates and sent their teams to Chapel Hill. Floyd Adams and Shearod Crumpler, of the Roanoke Rapids high school, representing the negative, won the Aycock Memorial Cup in the final debate on April 19, 1929.

One hundred and eighty-six schools took part in the eighteenth annual state-wide contest on April 4, 1930, on the query, RESOLVED, *That North Carolina should adopt the proposed constitutional amendment, authorizing the classification of property for taxation.* Fifty-one schools won both of their debates and sent their teams to the University. The Goldsboro high school, represented by Miss Eleanor Bizzell and Ezra

Griffin, on the negative, won the Aycock Memorial Cup in the final debate on April 18, 1930.

Two hundred and eighteen schools entered on April 3, 1931, the nineteenth annual state-wide contest on the question, RESOLVED, *That the United States should grant immediate independence to the Philippines.* Fifty-two schools won both of their debates and sent their teams to the University. Miss Marian Weil and Ezra Griffin, of the Goldsboro high school, representing the negative, won the Aycock Memorial Cup in the final debate on April 17, 1931.

Two hundred and fourteen schools took part in the twentieth annual state-wide contest on April 1, 1932, on the query, RESOLVED, *That the United States should adopt a system of compulsory unemployment insurance.* Fifty-five schools won both of their debates and sent their teams to Chapel Hill. The Curry high school, represented by Miss Katherine Keister and Nash Herndon, on the negative, won the Aycock Memorial Cup in the final debate on April 15, 1932.

Two hundred and fifteen schools entered the twenty-first annual state-wide debate on March 31, 1933, on the query, RESOLVED, *That North Carolina should adopt the sales tax as a feature of its state system of revenue.* Fifty-one high schools won both of their debates and sent their representatives to Chapel Hill. The Broughton high school, of Raleigh, represented by Miss Katherine Martin and Wade Marr, Jr., on the affirmative, won the Aycock Memorial Cup in the final debate on April 14, 1933.

Two hundred high schools participated in the twenty-second annual state-wide high school debate on March 30, 1934, on the query, RESOLVED, *That the United States should adopt the essential features of the British system of radio control and operation.* Forty-five high schools won both of their debates and sent their teams to the University. The Thomasville high school, represented by Miss Katharine Covington and A. C. Lovelace, Jr., on the affirmative, won the Aycock Memorial Cup in the final debate on April 13, 1934.

Two hundred and twenty-five high schools took part in the twenty-third annual state-wide high school debate on March 22, 1935, on the query, RESOLVED, *That the United States should adopt the policy of extending federal aid to general public education.* Sixty-eight high schools won both of their debates and sent their teams to Chapel Hill. The Goldsboro high school, represented by Powell Bland and Maurice Edwards, on the affirmative, won the Aycock Memorial Cup in the final debate on April 12, 1935.

## THE QUERY FOR 1935-36

The query which will be discussed this year by the high schools holding membership in the High School Debating Union is, RESOLVED, *That the several states should provide for the socialization of medicine.* The high school debating leagues of thirty-two states will discuss the subject of the socialization of medicine in their spring contests during this scholastic year. It is the hope of the central committee that the twenty-fourth

annual state-wide debating contest, dealing with the important question as to whether the several states should provide for the socializing of medicine, will prove one of the most successful contests that have yet been held. The attention of debaters and of all others interested in the contest is directed to the statement of the query, with the accompanying explanations and limitations of the meaning of the query, on pages 12 and 13 of this handbook.

The thanks of the compilers of this debate handbook are extended to the publishers and authors who very kindly gave permission for the reprinting of articles included in the handbook.

## REGULATIONS

1. The University Extension Division of the University of North Carolina will suggest a query, to be discussed on a given date by the schools entering the High School Debating Union.

2. All secondary schools of North Carolina, however supported, offering regularly organized courses of study above the seventh grade, and not extending in their scope and content beyond a standard high school or secondary school course, shall be eligible for membership in the High School Debating Union.

3. The schools accepting this offer and thus becoming members of the Union shall be arranged by the committee into groups of three for triangular debates, the status and standards of the schools, their proximity, accessibility, and convenience of location to be considered in forming the groups.

4. Each school of every triangular group shall agree to furnish two debating teams of two members each, the one to uphold the affirmative side of the query, and the other to defend the negative side.

5. The members of the debating teams must all be bona fide students of the schools they represent. To be bona fide students, they must be in regular attendance at the time of the debate, and they must have been in regular attendance for at least 30 per cent of the school year up to and including the date of the debate, and they must have made passing grades on a majority of the studies in some regularly organized course of study.

6. No post graduate of a school—that is, no student who has already finished a four-year high school course—shall be eligible to represent his school in the contest. This shall not serve, however, to debar those students who are in upper classes in school systems modeled after the junior-senior plan, unless these students have already been graduated from, or awarded diplomas by, the schools which they are now attending or other high schools. If such students have been graduated already, or awarded diplomas, they are, of course, ineligible to compete.

7. No student who became 21 years of age on or before September 1, 1935, shall be eligible to represent his school in the high school debates of the High School Debating Union.

8. The usual plan of procedure for the triangular contests will be for the affirmative teams to debate at home and for the negative teams to visit. However, whenever a plan for holding the debates on neutral

grounds is favored by at least two member schools of a given triangle, then the debates of that triangle will be held on neutral territory.

9. The schools themselves shall select and agree upon the judges of the local contests.

10. Each speaker shall have twenty minutes at his disposal, not more than fifteen of which shall be used in the first speech.

11. In the debates of the High School Debating Union, the order of the speakers in the first speech shall be: affirmative, negative, affirmative, negative. The order of speakers on rejoinder shall be: affirmative, negative, affirmative, negative. It is understood, however, that there is no objection to a reversal of this order of speakers on rejoinder in any given local debate, provided that such a reversal of order shall have been definitely agreed to beforehand by responsible authorities of both schools which are concerned in the given local debate.

12. The schools which shall win both of their debates shall be entitled to send their teams to the University to compete in the final contest for the Aycock Memorial Cup. It is understood, however, that the committee may arrange for a second triangular contest between the winning schools throughout the state prior to the final contest at the University, should this plan appear to be necessary under the circumstances. In this case, only those schools whose teams should win both debates in the second contest would be entitled to representation at Chapel Hill.

13. In the event that one school of a triangle drops out and the committee at Chapel Hill is unable to secure a school to take its place, then the two schools remaining shall hold a dual debate with one another, each school sending its team on the negative to the other.

14. In the event that two schools of a triangle drop out of the Union and the committee is unable to secure schools to take their places, then the remaining school shall be declared the winner over the others by their default.

15. The school having the strongest team on the affirmative side of the query and the school having the strongest team on the negative side shall be entitled to contest publicly at the University for the Aycock Memorial Cup. (The strongest team on each side of the query is to be determined by means of preliminary contests in debate at Chapel Hill.)

16. The school which shall win the debate, thus finally held, shall have its name inscribed on the Aycock Memorial Cup, together with the names of its two winning representatives.

17. Any school which shall win the final contest for two years in succession shall have the cup for its own property.

18. All contestants are expected to prepare their own speeches with legitimate assistance of the teachers, principals, or superintendents in their school systems. Legitimate assistance is interpreted to mean oral advice, suggestions, discussions, and criticisms.

## SUGGESTIONS AS TO JUDGES

1. The judges should be disinterested parties to the success of either team and, so far as possible, should be non-local.

2. They should sit apart during the debate.

3. They should judge the contest as a debate, and at its conclusion should vote "Affirmative" or "Negative" on the merits of the debate. They should not consider the merits of the question.

4. Each judge should sign and seal his vote and deliver it, through an usher, to the presiding officer who should publicly open the votes and announce the decision.

5. Before the debates begin, a copy of these suggestions should be given to each judge for his guidance.

## ORIGINALITY OF DEBATES

The committee realizes that "the debate which a speaker produces should be his very best; but it should under no circumstances be better than his best; that the success of the Union will be seriously hindered unless in each instance the speech of a debater represents his own individual work." It wishes, therefore, to ask the principals to give this matter their very careful consideration and to note particularly regulation 18. In cases where necessary, the principals in the various triangles should take such action among themselves as they deem necessary. Great care should be taken by all means to see to it that wherever a speaker uses any quoted material, proper credit is given in his speech to the source from which the quotation was derived.

For further information, address

E. R. RANKIN,

*Secretary, High School Debating Union, Chapel Hill, N. C.*

# QUERY

RESOLVED, *That the several states should provide for the socialization of medicine.*

## EXPLANATIONS AND LIMITATIONS

For the purpose of clarity of issue in the debates of the High School Debating Union of North Carolina, the following explanations and limitations of the meaning of the query are distinctly set down:

1. It is understood that the statement of the query, as this is given above, contemplates that the several states should make available complete medical care by licensed physicians for all citizens at public expense.

2. It is understood that the statement of the query contemplates that the several states should make available complete dental care by licensed dentists for all citizens at public expense.

3. It is understood that the statement of the query contemplates that the several states should make available to all citizens at public expense hospitalization, when necessary, and treatment in clinics, when necessary. This would include X-ray service.

4. It is understood that the statement of the query contemplates that the several states should make available at public expense those ordinary drugs which are necessary in the treatment of patients while they are in hospitals or clinics. Drugs would not be furnished free of charge except in the following cases: (a) when taken or administered in hospitals or clinics, (b) when necessary for immunization purposes outside of hospitals or clinics, and (c) in emergency cases outside of hospitals or clinics.

5. It is understood that the statement of the query contemplates that the several states should make available at public expense nurses' services for patients while they are in hospitals or clinics. This nursing service would not be secured at public expense unless the patients were in hospitals or clinics at the time.

6. It is understood that the statement of the query contemplates that the several states would set up boards to administer and supervise the various state systems of socialized medicine.

7. It is understood that the statement of the query contemplates that the several states might receive assistance in their programs of socialized medical care from counties, cities, towns, special districts, and from the federal government. That is, any medical services or assistance furnished by governmental agencies of any character, state, local, or federal, would be considered, for purposes of this debate, as parts of the state systems of socialized medicine. A city health department, for instance, would be considered as a feature of the state system of socialized medicine as well as a local health department.

8. It is understood that the statement of the query contemplates that the private practice of medicine would continue alongside of the state systems of medical care, to the extent that private practice might be

desired alike by physicians and by citizens. That is, there would be no prohibition of private medical practice nor of private dental practice nor of private hospitalization and clinical treatment.

9. It is understood that the several states would support the systems of socialized medical care through such taxes as they might choose to levy.

10. It is understood that any question as to the constitutionality of the proposed state systems of socialized medical care is to be waived from the discussions in the debates of the High School Debating Union.

# GENERAL REFERENCES

## SHALL MEDICINE BE SOCIALIZED?

(Excerpts from an article by R. L. Duffus in the New York Times for December 4, 1932, section 20, page 7.)

The results of America's first comprehensive survey of the economics of medical practice, made public last week by the committee on the costs of medical care after five years of study, reveal what may be described as a crisis in medical service.

They show that while the average pay of physicians and other health workers is not high and while the actual pay in individual cases is often insufficient, adequate medical attention is beyond the reach of many millions of people.

They reveal that while medical knowledge has been progressing rapidly for half a century or more, the application of that knowledge to the needs of the general public has lagged.

But when it comes to measures to meet the crisis there is disclosed a clash of philosophies, forcefully presented in the majority and minority reports of the committee. The majority group, expressing themselves in recommendations so sweeping as to come under the heading of revolutionary, see medicine as a social problem and responsibility, demanding reorganization and centralization. The minority see it as a function which can never be socialized, since in their opinion it must always resolve itself into a highly personal relation between physician and patient. There are already indications that the reports, in their radical divergence, will shake the medical world to the core.

Although without governmental authority, the committee has the prestige and influence of distinguished membership. Organized in 1927 and financed by eight foundations, it has done its work under the chairmanship of Dr. Ray Lyman Wilbur, the present secretary of the interior, and the research directorship of Dr. Harry H. Moore, formerly of the United States public health service. Twenty-five doctors of medicine, two dentists, two registered nurses, six public health teachers or executives, seven representatives of the social sciences, one engineer, one labor leader, one business man and philanthropist, and three women with broad connections in the field of social work make up its personnel.

A field and office staff of trained research workers, with the cooperation of various other official and unofficial organizations, has helped to carry out the announced program of "research in the various economic aspects of medical care." One million dollars was spent directly; services rendered without charge by individuals and organizations are estimated at $500,000 more.

The outcome, as seen by the committee's majority, is an indictment, not of individuals but of the prevailing system of organizing and paying for medical service. In the words of the majority report: "Many persons do not receive service which is adequate either in quantity or quality, and the costs of service are inequably distributed. The result is a tre-

mendous amount of preventable physical pain and mental anguish, needless deaths, economic inefficiency and social waste.

Into the picture enter figures staggering in their magnitude: an army of nearly 1,100,000 persons engaged in some phase of medical service; a total annual expenditure for such services of $3,647,000,000, or about 4 per cent of the national income in 1929; a capital investment of more than $3,000,000,000 in hospitals alone; deaths from any one of several largely preventable diseases annually exceeding several times over the battle losses of the American forces in the World War.

Into the picture also enter great changes in the nature of medical practice: the dwindling importance of the family doctor; the rise of specialists; the development of clinics, hospitals and industrial, collegiate and community medical services; the increasing perplexity of medicine, both in method and in the apparatus it requires, and a number of experiments looking toward health insurance.

The report may be divided into four sections. The first of these has to do with illness and its cost under the present system; the second, with attempts made to modify that system; the third, with the case for socialization as presented in the majority report, signed by Dr. Wilbur, chairman of the committee, and thirty-five of his associates; and the fourth, with the case for individualism as presented in the main minority report, signed by Dr. Olin West, secretary of the American Medical Association, and seven other physicians.

## I. THE PRESENT SYSTEM

From the mass of evidence a central factor emerges: our failure to make full use of our wealth of medical knowledge. As a profession, the committee finds, "medicine has gone forward with strides during the last century and especially during the last twenty-five years." But as an economic activity it has lagged.

The extent of illness is indicated by the committee's estimate that on the average every man has one disabling illness a year, this keeping him in bed from seven to nine days, and that every woman, on the average, has two such illnesses, these together keeping her in bed between eight and twelve days. About 700,000 persons at any given time are affected with tuberculosis, about 1,000,000 with venereal disease. Cancer takes nearly 120,000 lives a year, diseases of infancy nearly 136,000.

Mental defectives number a half million or more. If the World War ratio still holds, about one in five of all men of military age has a disease or defects which would incapacitate him for bearing arms.

At the same time variations in the death and sickness rates in different sections of the country and among different economic groups indicate that there is a close relation between income and health. The committee's figures point strongly to the conclusion that these variations are in part due to differences in the quantity and quality of medical care received.

At first glance the medical and allied personnel of the United States

is impressive in its magnitude. Nearly 1,100,000 persons are engaged in this field. In private practice there are 121,000 physicians, 56,800 dentists, 118,000 graduate nurses, 150,000 practical nurses, 47,000 midwives, 4,900 chiropodists, 20,200 optometrists, 7,700 osteopaths, 16,000 chiropractors, 2,500 naturopaths, and 10,000 religious healers. In addition there are connected with medical institutions or associated with the sale of medical commodities, 21,000 physicians, 5,600 dentists, 77,000 graduate nurses, 80,000 student nurses, 18,800 public health and industrial nurses, 132,000 pharmacists and a lay personnel, in hospitals, clinics and public health agencies, of 196,000. There are 922,000 hospital beds.

Of the $3,647,000,000 paid by the public in 1929 for the services rendered by this army of health workers, 78.5 per cent went for the care of illness, 17.4 per cent for dental care, 2.7 per cent for eye care, and only 1.4 per cent for the prevention of disease.

If evenly distributed over the country, properly qualified and accessible to everyone, the health army and its equipment might prove approximately adequate to the public's needs. Part of the present difficulty is that there are too many physicians, nurses and hospital beds in some parts of the country, and even in some sections of given communities, and not enough in others. Unemployment and under-employment exist in the field of medical service because many individuals, communities and even whole states and groups of states cannot afford to pay for adequate service.

If the twelve items, including savings, on which the American people annually spend more than $2,500,000,000 are listed, medical care, costing $3,647,000,000, stands sixth from the bottom. Education and recreation come close to the same level; the total spent for tobacco, soft drinks, confections and ice cream is less than $600,000,000 below it; more than twice as much is spent for automobiles. But the $30 a year which the average American spends on sickness is assessed with drastic unevenness, is demanded when he can least afford it, and falls hardest upon the poor.

There are startling geographical divergences. In 1929, the committee found, "there was one physician to every 1,431 persons in South Carolina, as contrasted with one to every 484 in California and one to every 583 in New York state." Dentists in 1928 ranged from 19 to each 100,000 persons in Mississippi to 101 to each 100,000 in Oregon. Wisconsin had one hospital bed for community use for each 154 persons, South Carolina one for each 749. In general, the lower the average income the fewer are the medical facilities.

The committee made a nation-wide survey of the illnesses and costs of medical service among 9,000 white families, arranging them according to different income levels and from less than $1,200 a year to more than $10,000 a year. It found that "the two or three lowest income groups receive far less of nearly every service—care from physicians and dentists, hospitalization, eye care, maternity care and X-ray and laboratory service—than the groups with highest incomes."

The lowest income group called the doctor less than half as often as the highest and visited the dentist less than one-fifth as often. Yet there was about as much sickness among the poorer families as among those which were well off. Among individuals earning between $1,200 and $2,000 a year, 57.8 per cent received some medical care; among those earning $10,000 or more, the percentage was 86.2.

These figures, which are taken to be typical, indicate that the poorer individuals and families are unable to pay for medical attention they need and that many of them are unable or unwilling to procure it from charity.

If the country's total medical bill were evenly divided among the population, each person would be charged $30 annually—a burden too heavy, probably, for at least one-fourth of the nation's families whose total incomes are $1,400 or less. But since sickness, in the absence of insurance, has to be paid for by those who suffer from it, many families in a given year pay much less than $30 a head and many others pay more. A committee study showed families with incomes under $2,000 paying an average family medical bill of $71.48, while those with incomes of $5,000 or more paid an average of $311.06. But these averages mean that many families in the $2,000 income group had to pay several times $71.48, while others paid little or nothing. Such facts as these led the committee majority to believe that the burden of medical costs must be distributed by means of a system of insurance if it is not to become disastrous to low-income families at the hour of their greatest need.

Despite the high cost to many of the patients, the dentists, nurses and hospitals were not found to be overpaid. The average net income of physicians, the committee found, was $5,300 in 1929. Half of the country's physicians were earning $3,800 or less. Dentists' incomes were on a similar footing. Only about 9 per cent of the country's hospital beds were controlled by profit-seeking organizations and practically all the other 91 per cent showed an annual deficit.

The situation, therefore, is that many millions of Americans either go without medical care or pay more than they can afford, while those who offer medical care receive, on the average, at least no more than an adequate return.

## II. COST EXPERIMENTS

With the growth of medical science the treatment of disease has grown more rather than less expensive, and this fact is justified by the belief that human life and health are worth what they cost. Some economies, the committee found, have been effected in certain instances by a better organization of medical service. But most contemporary efforts to ease the financial burden of sickness have looked less toward cutting the average cost than toward limiting the amount which any individual or family may expect to pay in a given year. This plan introduces the elements of health insurance or contract medicine or both.

Experiments toward this end have been undertaken by medical socie-

ties, by groups of consumers, by various communities, by industrial employers and commercial companies. Many of these experiments have been studied by the committee, and some of them may be given as illustrations.

Largely since the World War, a number of "private group clinics," organized by physicians, have been formed in the United States. These clinics have been able to cut the cost to the patient somewhat by reducing their "overhead" from general practitioners' 40 per cent of the gross receipts to from 20 to 33 per cent. Some of them furnish medical service for an annual fixed fee.

Medical services have grown up under workmen's compensation laws and have been voluntarily furnished by many corporations. In April, 1930, about 1,000,000 employes in the railroad, mining and lumbering industries were receiving care under this arrangement, usually on a monthly fee basis. Not all of this service, however, is of good quality. A few employers have attempted to furnish complete service at cost or free of charge. One large shoe manufacturing concern was able to give such service in 1928, including hospitalization, nursing and dentistry, at an annual cost to itself of $21.81 for every person to whom the service was available.

In other instances groups of employers provide medical care through mutual benefit associations; in still others employes and employers contribute to a mutual fund for this purpose.

A number of communities have tried to regulate the costs of sickness by voluntary associations, usually centering about hospitals. In thirty or more rural "municipalities," roughly equivalent to American counties, in the Canadian province of Saskatchewan, physicians have been hired out of tax money on a yearly salary to furnish service, at an annual cost ranging from $7.50 to $10 for each family. These communities were populated in part by American farmers who had moved across the border, and were studied by the committee as possible models for similar systems in American rural communities.

Health insurance on a commercial basis has gained but little momentum in the United States, but a number of cooperative moves in this direction have been made. In Dallas, Texas; Grinnell, Iowa; Brattleboro, Vermont; and New Bedford, Massachusetts, residents may insure themselves against hospital charges by paying a fixed sum per annum. More than 150 colleges and universities furnish medical services at costs of from $9 to $30 per school year per capita.

Much attention was paid by the committee to European systems of health insurance. The report points out that "during the past 50 years most European countries have made payment for medical care the subject of public action, and a large part of the population now pays for medical service through regular periodic payments to a mutual benefit society or sickness insurance 'fund'."

Usually, in such cases, both employes and employers contribute to these funds, and in many instances the government also contributes. The money is used both for medical expenses and to make up loss of

wages during illness. Hospital care is generally furnished by the state, except in Great Britain and Holland, and is not a part of the insurance plan. In Great Britain voluntary insurance for hospital care has been taken out by about 6,000,000 persons.

Most of the European systems of health insurance are compulsory upon all those below a specified income level. The benefits vary from the treatment of tuberculosis alone in Italy to a nearly complete medical service in Germany and Austria and the services of general practitioners in Great Britain. In Denmark and Sweden state-supervised voluntary systems have brought in nearly the whole population. In Great Britain the compulsory plan, inaugurated in 1912, was at first opposed by the British Medical Association. The association has now, according to the committee report, "officially recognized its benefits and advocated an extension of the scope of service and the inclusion of dependents."

Investigators for the committee, discussing the pros and cons of the system in Europe, reported that "there is practically no important opposition to the principle of health insurance in any country where it now exists"; that "national associations of physicians and dentists have, over and over, formally approved the provision of health care to the lower-income groups through insurance"; that "there is practically unanimous agreement that the insured receive better medical care than they did before they were insured"; that "medical incomes have probably not been diminished under insurance plans"; that "every attempt to apply the principles of voluntary insurance on a large scale has proved to be only a longer or shorter bridge to a compulsory system"; and that "in every insurance system there has been a fairly steady increase in the number of persons sick and in the number of days of sickness per capita annually."

## III. SOCIALIZATION

The majority recommendations, based on these studies, would, if accepted, represent a radical change in medical policy. They have already stirred up a vigorous controversy. It is therefore significant to note that 17 of the 25 committee members having M.D. degrees voted for them. The two dentists voted with the dissenters. The group representing the public voted solidly for the majority report, and the groups representing the institutions and special interests, public health and social sciences had only one dissenter each. In the case of the social sciences the dissenter objected because the committee had not gone far enough, rather than because it had gone too far.

Summarized, the majority recommendations are:

First, that the medical and allied services should be unified and grouped around hospitals;

Second, that public and private health services should be made "available to the entire population according to its needs";

Third, that "the costs of medical care should be placed on a group-payment basis, through the use of insurance, through the use of taxation, or through the use of both these methods";

Fourth, "that the study, evaluation, and coordination of medical service be considered important functions for every state and local community, that agencies be formed to exercise these functions, and that the coordination of rural with urban services receive special attention";

Fifth, "that standards of professional education should be broadened, by emphasizing preventive medicine and social elements in medical practice; by restricting specialization to those actually qualified; by widening the scope of dental education; by improved training for pharmacists and nurses; by providing training for practical nurses and nurse-midwives; and by offering opportunities for the systematic training of hospital and clinic administrators."

The debate now centering about the report is focused upon the first and third points in the program—the principle of "group medicine" and the principle of insurance.

"Group medicine" is intended to meet the difficulties arising from "the lack of coordination between general practitioners and specialists; the isolation of some practitioners from helpful contacts with their confrères and from hospitals and medical agencies; the lack of adequate supervision and control over the quality of some medical care; the enforced idleness of many physicians because of lack of patients; the difficulty experienced by patients in choosing qualified physicians; the unnecessarily large expenditure for overhead costs made by practitioners in individual private practice; and the increasing complexity of medical service which necessitates the use of ever-multiplying equipment as well as a larger number and variety of subsidiary personnel."

"Group practice" does not mean the elimination of the general practitioner; it does seem to mean the passing of the independent, self-sufficient physician of the old-fashioned family-doctor type. Under the community medical organization would be "all the needed therapeutic and preventive medical services except care for tuberculosis, mental disease or other conditions which have been accepted as governmental responsibilities."

"Group payment" is a logical deduction from "group practice." The committee majority agreed upon "voluntary cooperative health insurance," carried out through "industrial, fraternal, educational or other reasonably cohesive groups," as an immediate step. Nine members voted in favor of legislation in the industrial states which would "require all persons in certain income groups, certain occupations or certain areas to subscribe for health insurance." The employment of salaried or subsidized physicians in rural areas, with assistance from state governments or even from the federal government in cases where local funds were inadequate, was recommended by the majority.

## IV. INDIVIDUALISM

The leading minority report, signed by eight physicians, unquestionably expresses the attitude of the conservative elements in the American Medical Association and in the medical profession at large. The Journal of the American Medical Association, in an editorial in its current issue,

has already taken its stand with the minority, characterizing the issue as one "between incitement to revolution and a desire for gradual evolution based upon analysis and study" and charging bias in favor of health insurance and state medicine on the part of the director of studies and at least one of the committee's backers.

The minority report itself is, in certain passages, almost as caustic. It takes sharp exception to the belief that medical service can be made less costly or more efficient by such organizations as the proposed "community medical centers." It makes the pungent comment that "the idea that size and power are synonymous with excellence and efficiency has received some severe blows during the current economic depression, and opinions concerning it are undergoing revision." It contends that "the profession of medicine is a personal service and cannot adopt mass production methods without changing its character."

Specifically, it argues that the medical-center plan "would establish a medical hierarchy in every community to dictate who might practice medicine there" and that "continuous personal relationship of physician and patient would be difficult if not impossible under such conditions." It stresses the conviction that 85 per cent of all illnesses can be more advantageously treated "by the individual doctor in his own office than in a clinic, and at less cost." At the same time it approves the present association of physicians with hospitals and "the development of pay clinics when they are under the management and control of physicians and are conducted on a high ethical plane and are needed to meet a situation."

The minority report is vigorously opposed to insurance schemes on the ground that the voluntary element must in the end give way to compulsion, and that existing voluntary systems are already "giving rise to all the evils inherent in contract practice." These evils are described as "solicitations of patients, destructive competition among professional groups, inferior medical service, loss of personal relationship of patient and physician and demoralization of the professions." Compulsory insurance appears to the minority to have even greater evils.

The minority group, therefore, recommends restricting "governmental competition in the practice of medicine" to the care of the indigent and of the wards of the government; that attempts be made "to restore the general practitioner to the central place in medical practice"; that "the corporate practice of medicine, financed through intermediary agencies," be "vigorously and persistently opposed"; that physicians experiment with systems of lump payments or instalment payments, supplementing the fee-per-visit system; and that projects already being studied by medical societies to apportion the costs of illness among patients according to ability to pay, through agreements among the members of such societies, be put into effect. In principle this plan would meet some of the arguments which have been made against the present inequality of charges for medical service, and the minority believes that it would obviate the necessity of health insurance. It differs significantly from insurance schemes and community medical-center plans in that ultimate

control would be in the hands of the physicians themselves, limited only by a lay "grievance board."

It may be pointed out that a fundamental issue in the whole discussion aroused by the committee reports is the extent to which the laity may have a voice in determining medical policies. The more conservative physicians are stoutly against lay interference, contending that no layman is qualified to vote on medical policies or medical ethics. Control of physicians by lay organizations, for profit, is, of course, opposed by all medical men.

A further point made by the minority group, whose report has been outlined, is "that many of the problems which are under discussion are the general problems of a transitional stage in social development and are not peculiar to medicine or medical care," and that "their solution must depend upon far-reaching social and economic adjustments."

In addition to the minority report already quoted, minority statements were issued by Edgar Sydenstricker, a sociologist who refused to sign because, in his opinion, the majority recommendations did not "deal adequately with the fundamental economic question which the committee was formed primarily to study and consider"; by Drs. Herbert E. Phillips and C. E. Rudolph, dentists, who were in accord "with the general recommendations of the majority in favor of group practice and group payment," though differing in some details; and by Dr. Walton H. Hamilton, professor of law at Yale University, who maintains that the majority report is a compromise containing too few specific and clean-cut objectives, and that compulsory health insurance "is the very minimum which this committee should have recommended" as a means of meeting present-day needs without destroying medicine as an art.

"As the report puts it," Dr. Hamilton concludes, "the present situation presents a challenge. It is not a question of whether we can afford to pay for an adequate and comprehensive system of medical care. A social investment in health pays its own way and yields a surplus. The present system is a luxury which the American nation—rich as it is in resources—is too poor to afford."

That the report is, as Dr. Hamilton says, a "challenge" has already been established by its reception. It is the opening gun in a battle between individualism and socialization in medicine which promises to be of long duration.

## PLANNING FOR MEDICAL CARE

(Excerpts from an article by Charles-Edward A. Winslow in Current History, volume 41, pages 437-442, January, 1935.)

Country after country has introduced a program of sickness insurance, but none has ever abandoned it. In no nation have the political powers or the medical profession ever suggested a departure from the general principle, even if there is much to criticize in detail. Americans, profiting by European experience, should, however, be able to devise a program that might be intrinsically sounder and that would certainly be better

adapted to our own conditions and our own psychology than any which might be imported bodily from abroad.

So far as the personnel and resources for providing medical care are concerned, there has been a striking development in the United States during the past thirty years. Though the number of physicians has increased less rapidly than the population, the ratio of dentists and hospital beds has grown faster than the population; while the ratio of nurses to potential patients increased about ninefold between 1900 and 1920. Clinic service multiplied some twentyfold during the same period.

In 1929 there were over 1,000,000 people directly engaged in the provision of medical care and the sale of medical commodities. We had in that year 142,000 practitioners with the degree of doctor of medicine, or one per 800 population. There were 62,400 dentists in active service, or one to about 1,700; 200,000 trained nurses, or one to about 600; and over 900,000 hospital beds, or one bed to every 130 persons. We were spending annually for all forms of medical care, including hospitals, physicians, dentists, nurses, pharmacists, cultists, drugs and medicines, $3,656,000,000, or about $30 a person. Of this sum $2,885,790,000 was paid by patients themselves, the rest by industry and governmental or privately supported social agencies.

Dr. Roger Lee, of Boston, in a study made for the committee on the costs of medical care, estimated the personnel and facilities that would be needed for a complete system of medical care for the American people. He believed that if all the preventive and curative care called for by modern standards of medicine and public health were provided there would be need for only 7 per cent more physicians and about 20 per cent more nurses than are available today. Hospital beds would have to be increased by about 60 per cent, chiefly for tuberculosis and for mental and nervous diseases. The present supply of dentists is inadequate and should be increased by at least 75 per cent. The committee on the costs of medical care estimated that all these increased facilities could be enjoyed under an efficient system of medical practice—and with increased compensation for the professional personnel—at an average annual cost of $36 a person.

But it is not the presence of doctors and nurses in a community that determines good medical care; it is the extent to which their services are utilized. Are the doctors and dentists and nurses in the United States as professional groups actually rendering the service they could? Are the people of the United States actually receiving the service they should?

The most important single study of the committee on the costs of medical care was a survey of 9,000 families, living in 130 communities in 18 different states and representing various economic levels. Each family was observed for a year and, through repeated visits by a public health nurse, full records were obtained of all the illnesses that occurred and of all the medical care that was received.

The figures show that in spite of a supply of physicians theoretically adequate for nearly complete care, the actual contacts of these 9,000

families with physicians in home, office and clinic reached only 42 per cent of a desirable standard. Days of care in general hospitals alone—not including hospitals for tuberculosis and mental and nervous cases where there is a real lack of facilities—reached only 54 per cent of a desirable standard. Special nursing care in hospitals was 69 per cent below standard, dental care 76 per cent and health examinations 91 per cent.

To illustrate what the "standards" mean and their essential reasonableness, let us consider dental care. Dr. Lee and his colleagues estimated that every person over three years of age should make at least one visit a year to a dentist. Yet the records showed less than one-quarter as many visits to dentists as there were people over three years of age in the 9,000 families. From a comparison of actual service with the potential service which doctors, dentists, hospitals and nurses might provide, it would seem that these persons and agencies are operating at about half their potential efficiency.

Clearly there is something wrong here. It is not that individual doctors and dentists and nurses are not striving to meet the needs of suffering humanity. Though they are striving, only the most fortunate of them have full opportunity to give the service of which they are capable. What is the difficulty? Why do not the people who need service seek out the professional attendant who is waiting to help?

The answer is in part "ignorance and carelessness," but in much greater part it is "economic inhibition." Statistics show that the families with incomes of $10,000 and over do receive approximately adequate medical care except in the field of dentistry and in that of health examinations. These prosperous families have more than five-sixths of the medical and hospital care, nearly two-thirds of the dental care and more than the special nursing care postulated by the Lee standards—a fact which again suggests the reasonableness of those standards.

As we pass down the economic scale the proportion of medical care received grows progressively less. The decrease is consistent except in the case of hospital care, where the very poor (who occupy free ward beds) are better off than the middle levels. Only here is it even approximately true that "the very rich and the very poor receive good medical care." The two lower-income groups (under $1,200 and between $1,200 and $2,000) made up in 1929 about half our population. Yet at this time, before the depression, the lower half had only about one-third the medical care, less than two-thirds the hospital care, less than one-seventh the dental care and less than one-fifth the special nursing care called for by reasonable standards of adequacy. Over 45 per cent of the individuals in these lower-income groups never came into contact with a physician or a dentist during the twelve months of the survey.

This economic barrier can by no means be regarded as due to exorbitant charges on the part of the professional personnel concerned. Even in 1929, at the peak of prosperity, the average net income of all physicians in the United States was only $5,300. Half of them had net incomes below $3,800 and one-third below $2,500. Nurses in private

duty earned on the average (including maintenance) less than $1,600 a year. These figures are ridiculously low in relation to the training required and the grave responsibilities involved. Furthermore, as already pointed out, the total amount of money spent for all forms of medical care in the United States is by no means unreasonable.

The difficulty is, of course, that the average figure of $30 is meaningless. In 1929 Americans, on the average, spent $30 for medical care, $14 for liquor, $13 for tobacco and $12 for confectionery, ice cream and soft drinks. The latter averages are somewhat significant because the actual individual expenditure corresponds within reasonable limits to the average. But with medical care this is not so. Sickness is an emergency; and, in a given year with a given family, experience departs very widely indeed from an average figure.

Here are the facts as revealed by the studies of our 9,000 families: 16 per cent of the families spent less than $10 during the year for all forms of medical care, and 46 per cent spent less than $40. At the other extreme, nearly 4 per cent of the families spent over $500 and 1 per cent of the families spent over $1,000. In general, and in all the various income groups, one family in every hundred spent more than one-quarter of its annual income for medical care during the course of the year.

It is this hundredth family—the family which, in a given year, happens to be burdened with a severe illness—that is the heart of the whole problem. Except at the top of the economic scale such a sudden strain cannot possibly be met out of current income. Some families, as we have seen, go without care, placing a burden upon the generosity of the physician or the resources of the community. Some pay their way—but at the cost of sacrifices which may hang over them for years. Since the physician, the dentist and the nurse must live, charges to those who do pay must inevitably and necessarily cover the time spent in caring for free patients or in enforced idleness as a result of the failure of many potential patients to seek care. As charges to the paying group rise, more and more families are forced into the neglected or the non-paying groups.

The way to break this vicious circle seems obvious. Sickness is an emergency and the family that suffers severely in a given year is often unable to meet that emergency. Now other emergency costs—those arising from fire, burglary, automobile accidents or death—are covered by insurance, by regular annual payments which can be met with relative ease and which avoid crushing burdens when a crisis occurs. This is the logical way to deal with the emergency of illness.

At present a family with an income of $10,000 or over can ordinarily meet even the emergency costs of illness. Such a family is today obtaining reasonably good medical care and is paying for it. Below that level is a large section of the community which is unable to pay the costs of serious illness and which goes without care or fails to pay for what it receives. Yet this great middle group could pay for all the care required if the cost were distributed on an annual payment basis through a system of insurance.

Further down the economic scale are families which could pay at least a part of the average cost of medical care, while at a still lower level are others which gain a bare subsistence or less. Here, the resources of the state or of the voluntary social agencies must be called into play.

We have come to recognize—in theory—the obligation to provide medical care for those who cannot pay, but we do it in such a way that families below the $1,200 level actually fail to receive the care they need. With a comprehensive insurance scheme, supplemented at the lower economic levels by a dignified and regularized system of subsidy, doctors and dentists and nurses could be better paid than at present, hospitals better supported and reasonably adequate care provided for the whole population of the United States. The total cost need not be materially greater than the sum of $30 per person per year now being spent for grossly inadequate care.

Arguments of this sort have induced practically all the nations of western Europe to establish systems of sickness insurance. These systems differ in detail; but they all embody the same general principles. The industrial worker below a certain income level must contribute a fixed weekly sum to an insurance fund, a contribution which is supplemented by others from the employer and from the state. When a worker is ill the fund provides a cash benefit for a part of his lost wages and for at least a portion of his medical care.

In the United States the mistake should be avoided of combining medical benefits and cash benefits to cover wage loss. Both are desirable but the attempt to operate them under the same system has caused the most serious difficulties in the working of the European schemes. Secondly, we should seek through medical benefits a more complete coverage than in many European plans. Great Britain's insurance law, for example, provides medical benefits which cover only home calls or office visits of a general practitioner. This seems like insuring against only those risks which least need the protection of insurance. Treatment by specialists and hospital care make up the most variable items in the medical bill. They constitute the grave emergencies of illness.

Obviously such a plan involves changes in medical practice as well as in medical payment. If insurance fees are paid only to general practitioners in their offices nothing more adequate can be furnished in the way of service than that provided by the British panel system. If, on the other hand, complete protection is desired, we must deal with groups of practitioners, including specialists as well as general practitioners, dentists and nurses as well as physicians, and these groups must be affiliated with hospitals that can offer institutional care of bed cases.

Group organization of practitioners and agencies has at least two other outstanding advantages. In the first place substantial economies are made possible. Individualistic medicine raises overhead costs since the professional and clerical equipment needed in each office involves wasteful duplication; about 40 per cent of the average physician's receipts are consumed in overhead. Under the present system of practice the time of the personnel is also wasted. The average physician,

particularly in the years immediately following graduation, spends a large part of his time waiting for patients, while the older man, with unusual capacity in some particular field, attends to routine functions which a younger man could perform quite as well.

Study by the committee on the costs of medical care clearly revealed the economies involved in organized as compared with unorganized medical service. At Lead, S. D., the employes of the Homestake Mining Company obtained for $71,000 medical service which at current local rates would have cost $175,000. Yet the incomes of the company physicians compared favorably with the earnings of private practitioners in the same area.

Finally, it may be claimed that only through organized group practice can the quality of medical service be maintained at a reasonably high level. Those who know the kind of medical care received by persons on the lower and middle economic levels cannot ignore the seriousness of this problem. It is one that outside agencies cannot solve. Only the medical profession itself can safeguard the quality of medical service, and then only through some degree of group responsibility.

How shall such groups be organized? The committee on the costs of medical care suggested that they be developed by the profession itself with the local hospital as a nucleus. Such a grouping might be carried so far that practically all the physicians, dentists and private duty nurses in a given community would be on the staff of one or the other of its community hospitals. These groups would be organized as our hospital staffs are organized today under qualified heads, with all professional policies directed by the professional groups concerned.

## THE CASE OF THE ROSS-LOOS CLINIC

(Excerpts from an article by Mary Ross in the Survey Graphic, volume 24, pages 300-304, 315-316, June, 1935.)

The Ross-Loos clinic is preeminent in our American experience in offering benefits of both group payment and group practice to a large number of families in the general population. In the army, in some industries, and in the colleges, special groups of people can get a rounded and organized medical service for a stated amount a year, but almost nowhere else in this country—and probably nowhere on such a scale and at so moderate a cost—is this kind of care open to any group of employed people and their families who wish to apply. Only groups of employed people are eligible for care at annual rates. The Ross-Loos doctors care for any patients who wish to consult them, but for individuals fees are set as in ordinary private practice, based on the amount and nature of the service the patient receives. These fees, which constitute only a small part of the group's earnings, are pooled in the general income account.

Going into the medical group's central clinic building is like entering one of the office buildings in any large city in which many doctors have their individual offices. A patient comes by appointment with one or

another of the doctors and is received by a clerk at the central desk where medical records are filed. He sees the same doctor each time, unless a change in his ailment calls for a shift to some other doctor or a specialist on the staff. If a patient does not strike up a congenial relation with the doctor to whom he first is referred, he has only to ask at the desk to try another. Originally an apartment house, the four-story building has been remodeled to provide many suites of private offices for the doctors, each with its reception and treatment rooms. On the street level the group maintains its own drugstore, while upper floors house laboratory services, therapy rooms, the staff library, and operating rooms for minor surgery which does not necessitate an overnight stay. When major surgery or longer hospital care is required, patients are taken to a Class A hospital where a floor and a half are reserved for Ross-Loos patients. Ambulance service is available day or night. Physicians and surgeons, of course, also are on duty or on call through the twenty-four hours for care needed by patients in their homes. In the offices of the central building and in the three branch offices in outlying parts of the city, both the furnishings and the general atmosphere of courtesy and order are such as any successful practitioner might be pleased to provide for his private patients.

Group service on an annual payment basis started in April, 1929, for 2008 employes of the Los Angeles department of water and power and their families. They had come to Dr. Ross and Dr. Loos to ask for care for their members at a flat annual rate, an arrangement which has been widely developed by many of California's large industries, especially the railroads and lumber companies. The two doctors at first declined, but were persuaded to try a plan as an experiment. By January, 1930, firemen and county employes had asked to come in and subscribers numbered 3137, and in succeeding years other groups applied to swell a steadily growing membership. The start of 1931 showed 5960 on the lists; by 1932 there were 8069; 1933, 9205; 1934, 11,822; 1935, 12,576. In each case agreements included provisions not only for the actual subscribers but their dependents. The 12,576 subscribers on the books at the close of 1934 had 25,365 dependents, among them parents, spouses and children; grandparents and grandchildren, in-laws, aunts, uncles, and cousins and even wards and proteges.

Each subscriber pays $2 a month through his association or club. This entitles him to any medical or surgical service he may require at home, office or hospital, except care obligatory under the workmen's compensation act and treatment for venereal diseases, for which a charge of 50 cents a visit plus cost of medicine is made. It includes any needed operation, ambulance service, consultations, X-rays, laboratory tests and drugs, with the exception noted above; general nursing; and hospital care in a ward up to ninety days during a year, except for obstetrical cases in which the subscribers pay hospital cost. It does not include dentistry, special nursing, radium treatments or hypodermic medication. The initial agreements also provided dependents with most of these services, except hospitalization and drugs, for the

$2 monthly fee. Further experience and the increase in numbers of dependents during the depression has made it necessary to modify the arrangement in recent agreements. Now small fees are set for various services to dependents—50 cents for an office visit and $1 for a home call, $25 for a major operation, and $20 for a confinement case, including prenatal and postnatal care. No change was made in existing agreements.

In 1934 the payments of the Ross-Loos subscribers for medical and hospital care averaged $2.69 a family a month, including all charges to subscribers for their dependents. This average is less than half the average costs for medical and hospital care incurred by similar urban families included in a 1934 survey by the California SERA who were paying sickness bills in the usual way. Averages, moreover, mean something when one is discussing Ross-Loos bills. In general, sickness bills vary so widely from family to family that an average is only the roughest sort of a guide to actual experience. For the SERA families with $1,200 to $2,000 a year, for example, the average total sickness bill during a three-month period was $19.50, but actual bills during that period ranged from 15 cents to $393 a family. While the costs of the Ross-Loos subscribers also vary somewhat because of the bills of the dependents, the range is far less; for the breadwinner of the family there is little likelihood of added charges and for the others the possible items are limited to the moderate and stipulated amounts, such as the $25 fee for a major operation.

This general averaging up represents the protection that a group of people get when the insurance principle is applied to bills as uneven and unforeseeable as those for sickness. The further economy they receive from the organization of group practice is shown in compilations which the Ross-Loos medical group recently worked out from their 1934 records. Taking the number of home and office visits, days of hospital care, operations and so on which their people actually received during the year, they figured what the cost would have been if these services had been purchased at modest rates in individual private practice: $2 for an office or hospital call, $3 for a home visit, regardless of distance or whether it was made by day or night; $20 for a minor and $50 for a major operation; and $7.50 a day for hospital care, including all the accessory charges of medicine, drugs, X-rays, surgery, laboratory and so on. At these rates the services which the subscribers obtained in 1934 for an average of $2.69 a month would have cost them $4.49, more than half as much again. The difference between those two figures may be taken fairly to represent economies inherent in group practice when it is combined with a group payment plan under which patients are able to use the doctor's time efficiently. It is a conservative estimate since many patients undoubtedly would have paid rates higher than those assumed, and no estimate at all has been included for the costs of drugs and prescriptions, which are provided through the pharmacy to subscribers without charge and to their dependents at less than usual retail rates. Even more significant, along with the economies this

charge gave protection to all from the financial disaster that breaks family budgets when serious sickness comes.

## THE COSTS OF MEDICAL CARE

(Excerpts from an article by Ray Lyman Wilbur in the Scientific Monthly, volume 39, pages 235-239, September, 1934.)

The provision of adequate scientific medical service to all the people, rich and poor, at costs which can be reasonably met by them in their respective stations in life, is of vital concern to every one here in this country, for in every city, town and village are people suffering from rheumatism, cancer, diabetes, tuberculosis and other ailments. Thousands of persons, even in "good times," try to get along without the medical service they need. Hundreds of thousands postpone seeing the physician or dentist or going to the hospital because they are afraid the charge will be too high. Even among the wealthy it is only a small percentage who obtain all the preventive care that they really need.

This lack of adequate medical service lays a burden of pain, suffering and inefficiency on this nation which, rich as it is, exceeds what we can afford. The question which faces the American people in the next ten years is not whether we can afford to provide ourselves with satisfactory medical service, but rather whether we can afford to provide less than adequate health care.

The committee on the costs of medical care agreed that a satisfactory medical service was one which would fully meet the following essentials: (1) Safeguards the quality of medical care and preserves the essential personal relation between patient and physician; (2) meets the true needs of substantially all the people.

It should provide service on financial terms which the people can and will meet without undue hardship either through individual or collective resources. No one who has examined the data which have been gathered by the committee can doubt that the cost of medical care often constitutes a serious obstacle to a proper distribution of medical service.

A satisfactory medical program must also utilize known preventive measures. The old saw about "an ounce of prevention" is vitally true in the medical field. If we are to keep the costs of medical care within reason, we must make our major economy through the prevention of disease.

Our problem requires that we make full use of existing medical facilities, which can best be done by organizing many of them into medical centers; that we retain in any program the confidence and support and leadership of the trained medical profession, without whom no satisfactory plan can be brought into being; and that we provide some form of payment for medical services which will spread the load over both sick and well and over all elements in the population. I see no escape from the insurance principle, if medical care is to be given to those who need it and the physician and hospital are to be paid.

What difference does it make to a physician whether he is paid

directly from the checking account of the patient or from a collective fund to which the patient has contributed? The essential thing is that the physician and not a bureaucrat determines all medical phases of the care of any patient, and that the patient has a voice in the selection of his medical attendant.

When we come to the question that was faced by the committee as to whether these group payments are to take the form of voluntary or compulsory contributions, naturally we meet differences in viewpoint that can only be worked out in time. We felt in the committee that it was safer to start off with the voluntary method, for we feared that the compulsory method carried out too soon with vigor and enthusiasm of legislative bodies (which might have members who want to be re-elected on a popular cause) might project us into a field from which we might later wish to retreat. But if, after a few years, we have been able to demonstrate that there is a willingness to meet this charge, and only those who fail to meet it are reluctant or negligent or indigent, then we can see our way toward some plan that may have the compulsory feature in it. In other words, we can develop a plan of compulsory health insurance gradually, if that should prove to be the answer.

The costs, as brought out by the committee, are not staggering—$20 to $40 per person per year. Using our present facilities, it is not a great cost when we think of how much many pay now who have more than the ordinary amount of illness to face. If we organize our talent for producing medical services economically and efficiently, a task well within the scope of America's peculiar genius, if we give thought to our navigating problems and plan our course to take fullest advantage of the wind, the waves and the strength and speed of our ship, we shall undoubtedly find that the cost is not too great for our present society. For inadequate medical services, produced with all the wastes inherent in individualized practice, we now pay about $30 per capita annually. With organized, coordinated effort we should be able to provide ample medical services of good quality to all the people and with proper remuneration to the professional personnel for a cost of somewhere between $20 and $50 per capita per year.

Throughout the nation we have had many different schemes given a trial. There is a tremendous ferment working in our medical system. Both doctors and laymen are reaching out in various directions to find methods of leveling the cost of medical service and of providing a better quality of care than has previously been available. Where this evolution will take us, we know not. That it contains dangerous as well as hopeful possibilities is apparent. If the costs of medical care can be approached without prejudice and preconception, if we can get the doctor to go at this problem of the social reconstruction of medicine in the same way he would take up the treatment of an old disease by a new method, we can offer to the American people the greatest opportunity for happiness that can come to them from any present source.

It seems that American ways of providing medical care for all on a basis that retains dignity and self-respect are available. By coopera-

tion and weighed experimentation the best plans can be rapidly evolved on the basis of the facts presented by the committee on the costs of medical care.

## GROUP MEDICINE AND THE DOCTORS

(Excerpts from an article by William Gaver in Scribner's Magazine, volume 98, pages 46-48, July, 1935.)

Medicine, like industry, has outdistanced itself. It has progressed scientifically during the past few decades much faster than it has developed resources for utilization of its findings. In the case of industry, the result has been the development of a productive capacity for which adequate means of social utilization are yet to be found. In the case of medicine, the knowledge of the causes of many diseases, of new technics of diagnosis, and of new methods of prevention and care has confronted the medical profession with the problem of making available to society as a whole the full benefits that modern medicine can bestow.

The time was—and not so long ago—when medical knowledge was represented, substantially, in the person of the family doctor. His diagnostic laboratory, surgical cabinet, and pharmaceutical store he carried in his small handbag. If his scientific knowledge was scanty, at least his patients received as adequate treatment as the medical profession of the day was prepared to give.

Today it would be impossible for any single individual to occupy such a role. Not only is the scope of medical knowledge too broad, but also the laboratory facilities and other types of equipment necessary for the full application of modern medicine are too numerous and costly for one individual to possess.

It is often claimed that the old-fashioned family physician compensated in "art" for what he lacked in science; that his intimate personal relationship with the patient, with the patient's family background, habits, and health history gave him an intuitive insight that furnished a truer picture of the ailment than would laboratory findings. Granting the element of truth in this, one is still inclined to suspect, that, by and large, a patient who is subjected to a thorough diagnostic routine by several specialists is in measurably less danger of having a tubercular cough diagnosed as a prolonged cold, or an appendicitis pain as simple indigestion, or a cancerous growth as a harmless tumor, than a patient whose ailment is diagnosed by a single doctor without modern laboratory equipment.

An urgent problem, therefore—and one that is receiving much attention—is that of making the complete resources of modern medicine available to all classes of people, rich and poor, rural and urban. As everyone knows, this problem is partly met by governmental agencies, which have taken over public health, sanitation, and preventive medicine. Free clinics and free hospital wards supplement this work. But when it is considered that of the 123 millions of people in the United States 60 per cent are ill annually, and that these people are distributed over

the length and breadth of the land, many of them far removed from hospitals or public health agencies of any kind, it seems obvious that all the existing health services combined barely scratch the surface of the problem.

Group practice had its most active growth in the United States during the periods from 1912 to 1921 and from 1922 to 1931. The rate of growth has shown a tendency to accelerate during times of prosperity and to slow down during times of adversity. Of recent years the trend has been toward smaller groups. There are only seven states, all of them either western or mid-western, which have ten or more groups. Texas, with 27, heads the list; and Wisconsin, with 23, is next. The greater popularity of the group plan in the western section of the country is due, no doubt, to the fact that there are fewer very large cities in those sections than in the east. For some reason, only 4 per cent of all the groups in the country are in cities of 500,000 or more.

Perhaps, the most significant—and certainly the broadest scale—experiment that has thus far been undertaken in actual practice with the group plan is that of the county medical society of Wayne county, Michigan, which embraces Detroit, Dearborn, and other important industrial centers. There, group medicine is practiced by the society as a whole, the organization's headquarters being used as the main offices of the groups and the offices of individual members as laboratory and clinical facilities. Upon applying for treatment, a patient becomes, in a sense, the responsibility of the entire membership of the society. His family physician, as a member of the group, feels free to refer the patient to whatever specialists may seem needed, without fear of losing contact with his patient by being excluded from the case. A particularly interesting feature of this plan is the arrangement that has been worked out for taking care of patients who are unable to pay the full amount of the normal medical fees. Together with his family physician, the patient agrees upon what percentage of the fee he can reasonably expect to pay and that percentage holds good with any other doctors to whom he may be referred.

Well, what is the answer? Is Wayne county pointing the way? Will group medicine in any form fill the bill? On one point every one seems to be agreed: the necessity of working out some plan for placing the full benefits of modern medicine within the reach of every person of every class. No one disputes the fact that there is at present a maladjustment in the application of medical care to the needs of the people. No one disputes the fact that in our modern complex civilization medicine has far-reaching social obligations that cannot be ignored. Group medicine may, or may not, be the final answer. But, at least, it represents a groping toward a solution of a problem that is of vital concern to all of us. And for this reason, if no other, it deserves the open-minded and sympathetic consideration of every one.

## THE BURDEN OF MEDICAL COSTS

(Editorial, reprinted by special permission from the Saturday Evening Post, volume 205, page 20, February 4, 1933. Copyright 1935, by the Curtis Publishing Company.)

In a normal year, the American people spend more than three and a half billion dollars on medical services, and the livelihood of a million individuals depends upon furnishing this aid. But the people do not complain of medical costs because of the total or average amount; the burden is due to the uneven, irregular and unpredictable expense of sudden or extreme illness. Many families go for long periods of time without spending more than trifling sums for these services, and then an operation or a serious illness, together with hospitalization, nursing, dentistry, X-ray and other items, falls upon them with catastrophic financial violence.

For more than five years, a committee of physicians and laymen has been studying the subject, and in its recent and final report, or rather reports, there is the sharpest possible difference of opinion. The majority, consisting of nearly all the laymen and the larger number of physicians, recommends that medical service be furnished mainly by organized groups of physicians, dentists, nurses, pharmacists, and the like, preferably centering around a hospital, and rendering complete home, office and hospital care. It further recommends that the cost be met through some form of insurance. A considerable minority of the committee, consisting entirely of physicians, emphasizes the evils of health insurance in European countries, deplores the adoption of mass-production methods in medicine and declares that the majority's whole idea illustrates what is an obsession with many people—namely, that "organization" can cure most, if not all, human ills.

Persons who belong to the more fortunate income groups, from five or ten thousand dollars upward, are heedless in not providing savings-bank accounts or other reserves of their own against the contingency of expensive illness. Also there is point in the recommendation of the minority report that less of the burden of caring for illness among indigent classes be thrust upon the medical profession itself. But neither of these suggestions quite goes to the heart of the problem. Despite the marvelous advances in medical science and the recognized devotion and skill of so many of its practitioners, the prevailing method of purchasing medical care has some unsatisfactory consequences. It often leads to unwise, wasteful, inadequate and undirected expenditures, and often to inequable remunerations of practitioners.

Even the minority of the committee, with all its vigorous opposition to mass production, tacitly admits that everything is not well with the present system. It admits the evil of charging separately for each visit and for different parts of the service in chronic diseases, and recommends a system of inclusive fees for definite periods of time. It suggests, also, experimenting with the county-medical-society plan of providing complete medical care.

The layman who reads these reports is sure to be puzzled by the conflicting viewpoints, even though couched in non-technical language. But the reports are well worth assembling, if only to stimulate discussion. Medical costs must be met, and they can be met with less suffering than at present. Most European countries have developed organized systems of medical care. They may not have proceeded with the greatest wisdom, but they have acted. It is neither necessary nor wise to develop socialistic medical systems in this country. But by concerted and carefully planned efforts, the existing facilities can be used with less waste and hardship than now.

## SICKNESS INSURANCE IN FOREIGN COUNTRIES

(Excerpts from "Sickness Insurance and Group Hospitalization," Editorial Research Reports, volume 2, number 2, 1934, prepared by Joel I. Seidman.)

State provisions for sickness insurance are found in 36 countries. In 21 countries, including most of the leading industrial nations, the plan is compulsory for certain groups in the population. In 12 countries sickness insurance is voluntary, and in three both types exist, with different classes of people covered by each. In some of the countries with voluntary insurance, medical care and indemnification for loss of earnings due to sickness are provided by government-subsidized mutual benefit associations.

The cost of sickness insurance is customarily met by periodic contributions from employers and employes, with the state in some instances contributing directly or assuming some of the administrative expense. The chief emphasis has usually been upon the payment of cash benefits to compensate for the loss of earnings during illness. This contrasts with most American proposals, which provide only for hospitalization and medical care. In most countries the cash benefit paid ranges from half to two-thirds of the wages usually earned. Benefits are usually limited to 26 weeks. Benefits for dependents are absent from some of the plans, permissive in others, and compulsory in five or six of the newer systems.

The Danish voluntary system covers a larger proportion of the populace than any other plan, compulsory or voluntary, with 45 per cent of the people belonging to recognized funds in 1930. Belgium had the next most extensive coverage among voluntary plans, with about 15 per cent. Among compulsory plans, Great Britain and Germany have the highest coverage, with 36 and 32 per cent, respectively. If dependents were included, however, the German percentage would be about 58 per cent. In some countries, including Finland, Italy, and Spain, the proportion of the population insured is as low as 2 per cent.

The English plan dates from 1911, with health insurance now compulsory for all persons of moderate means. Fixed cash payments are made without regard to former earnings, the rate being reduced after 26 weeks of continued sickness. Medical attention from a general prac-

titioner, together with necessary drugs, is provided in the plan, but hospitalization is not regularly available. Approved voluntary sickness organizations, now numbering about 1,000, are included in the plan, and entrusted with the administration of benefits. Persons of low income in many instances obtain hospitalization through semi-charitable "contributory schemes," in which the contributors pay low annual amounts intended to provide only part of the necessary costs. The British Medical Association, which strongly opposed the health insurance law when it was passed, now endorses it.

Germany has the oldest existing governmental plan, established by Bismarck in 1883. Originally limited to industrial workers, it has been extended to include commercial workers, domestic servants, and agricultural laborers. In addition to cash payments and medical care, maternity and funeral benefits are paid.

Russia has a system of state medicine, with all health institutions controlled by the state. Medical service is furnished by the local branches of the commissariat of public health, the full cost of all insurance for wage earners being paid by the state as employer. Frequent examinations are made, and a patient is treated as a member of the community whose efficiency must be increased if possible. Expectant mothers are required to stop work for eight weeks before confinement and eight weeks after delivery, at full pay.

Under the Soviet regime there has been an enormous increase in the amount of hospital accommodations and in the number of physicians. The physician has been removed from the field of monetary competition, and private practice at the present time probably constitutes less than 10 per cent of medical treatment.

# AFFIRMATIVE REFERENCES

## A PLEA FOR SOCIALIZED MEDICINE

(Excerpts from an article by George W. Aspinwall in the American Mercury, volume 33, pages 34-40, September, 1934.)

The practice of medicine is antiquated. The science of medicine has made and is constantly making progress. The general practitioner is rapidly disappearing. The know-it-all and the do-it-all doctor is a person of the past. Efficient medical practice can only be obtained through groups of doctors. These groups contain specialists in the various branches of medicine. With proper integration and cooperation in such groups the patient receives the best medical attention.

It has been shown often enough that the public does not receive proper medical care. The poor receive little attention for minor ailments. When the sickness is severe, the poor receive through charitable agencies the best treatment that medical science can supply. The middle class, which constitutes the majority of the population, does not receive adequate medical care. When severe illness occurs, they cannot afford to buy medical attention themselves. Hence they either neglect themselves or they seek charitable or semi-charitable help. The rich pay for medical care and obtain the best that is available. It has been suggested that the cost of medical care be spread throughout the population. By this means the expenditure of large sums of money for a severe illness will not fall upon an individual or a family group during a short period.

The income of doctors from the practice of medicine is rapidly decreasing. It is worse in 1934 than it was in 1933. There are still some doctors whose incomes are from $50,000 to $150,000 yearly, but the earnings of many physicians have shrunk below the subsistence level. The reason for the constant shrinking of the income of doctors is that more and more people are receiving medical charity each year. Unless some change is made in the method by which medical service is dispensed, chaos among doctors will occur. Symptoms of this are already in evidence.

Singly and in groups, doctors are clamoring for the correction of abuses which have curtailed their income. They desire that doctors be paid for services to the poor, that people who are not entitled to charity should be excluded from clinics, and that the activities of pay clinics should be curtailed or abolished and public health agencies be compelled to stop practicing medicine. But the consensus of expert opinion is that such changes will not really help the doctor or the public.

The committee for the study of the cost of medical care recommended that a drastic change in medical practice be made, but the American Medical Association has stated many times since that it looks with disfavor upon all changes. Last year the delegates to the American Medical Association instructed the trustees to use every effort to stop any movement for a change by the profession itself. Among the

delegates there were many doctors whose incomes are quite large. Some of them have been accused of obstructing the trend toward socialized medicine because of the fear that if an alteration occurs, their incomes will be leveled with that of all physicians. (That many members of the American Medical Association are not in accord with its policies is seen from the fact that the American College of Surgeons has endorsed some form of health insurance.)

The agencies that supply medical services are doctors, dentists, nurses, druggists, hospitals and other factors too numerous to mention. They have a large stake in the matter because a change in practice will alter their economic status. The public pays the bill; it therefore must be thoroughly informed about all of its phases.

Health insurance has been suggested by some and state medicine by others. Health insurance is generally a system of medical practice which includes only a part of the population and some of the doctors. It is usually related to unemployment insurance, though plans have been formulated in which employment security is not a feature. State medicine is a system that includes the entire population and all of the agencies which render medical service. Some of the advantages and disadvantages of each system will now be considered.

Health insurance organizations exist in many countries, particularly in Europe. They are applicable mainly to the working class with incomes of $1,200 a year or less. The employer, employe and government each contribute one-third of the cost. In some countries the government pays less. However, pressure is always being used by health insurance societies to force the government to shoulder more and more of the financial burdens. This would allow politicians to dictate the policies and the personnel of the societies. Labor organizations have always objected to health insurance because they feel that the worker should receive a return for his labor sufficient to allow him to pay for his medical care.

The system, as it now exists, has lowered living standards, since the worker pays part of his salary for health insurance and continues giving, without interruption, throughout his entire life. The employer raises the price of goods so as to offset the outlay for health insurance. By so doing the burden is thrown on the purchasing public. Employers will not submit to a reduction of earning for the public benefit.

The government must levy taxes in accordance with its needs. When sickness insurance came into being, taxes were raised. Each time the government contributes more money to health insurance, a greater levy is demanded from the public. The worker, therefore, pays for most of the expense of health insurance and is impoverished thereby. In a number of health insurance schemes, the dependents of the worker receive equal benefits but are not required to make cash payments. In others, the wage earner is compelled to pay for the medical care of those dependent upon him.

In health insurance no provision is usually made for dental care or the prevention of disease. The burden for the latter is borne by the

public health agencies. It is obvious that the general public, through taxation, pays more than its just share for the care of a favored group in the population.

Schemes for medical service have been advocated for groups earning from $1,200 to $3,000 yearly. Unpredictable severe illnessses may occur in families whose earnings are above this figure. Many instances are on record showing that the care for some of these illnesses consumes 100 per cent or more of the total income, if all of the agencies necessary for the care of the sick person or persons are adequately paid. It usually happens, however, that the doctor and other medical aids are compelled to accept less than their just compensation. Even charitable agencies are finally called in to subsidize the family in its extremity. It becomes necessary, therefore, to seek methods by which the entire population may obtain medical care commensurate with its needs.

State medicine (socialized or public) would supply all the desirable elements toward the solution of this problem. The salient features of the program of the Medical League for Socialized Medicine are as follows:

Adequate medical care for the sick and injured is a social function, right and duty, not a private nor public charity. State medicine is a socialized system of medical care in health, illness and injury, free of fees, under the auspices of the state and financed by taxation. It should be operated and regulated by organized medical and allied professions, the medical and dental colleges, and the officials of public health agencies. It should include all dental, pharmaceutical, nursing and allied services.

All buildings, supplies and apparatus are to be publicly owned. The hospitals and clinics should be organized as medical centers properly coordinated and geographically distributed. Calls for attendants upon the sick at home are to be received at these centers, such calls to be assigned to physicians designated to cover specific local territories. All equipment, supplies, laboratory and other facilities of medical, surgical, dental, pharmaceutical, nursing or other nature are to be furnished free. The education of the medical, dental, pharmaceutical, nursing and allied personnel is to be supplied free by the state.

All duly licensed or registered dentists, pharmacists and nurses are to be legally entitled to practice under this system on a full time basis, subject to established rules and regulations of admission and practice. Their rights and privileges are to be safeguarded and they should have representation and a voice in the operation of the system. The compensation should be adequate and graded according to time of graduation, length of service, rank and type of work. Salary increases and promotions to higher positions are to be based upon similar considerations and automatically enforced. Pensions and sickness, old age and other disability insurance are to be included. The hours of work should be assigned, regulated and scheduled, so that provisions be made for competent medical care for the sick and injured at all times. Adequate

time and opportunity for all professional workers should be allotted for rest, recreation, vacations, and post-graduate study with pay.

Group methods of practice are to be employed wherever possible and special provisions made for rural and other territories inaccessible to regular, organized medical centers. Private practice is permissible under the same conditions and regulations as in public education.

It is unlikely that this program, if adopted, will be put into effect in its entirety. Changes of this kind can occur only gradually; otherwise failure in its establishment may be safely predicted. The history of public education is a case in point. Its beginning was small, yet gradually it has expanded to the position it now holds and its cost is far beyond the dreams of those who originally proposed it.

It should be known that in this country, partial state medicine already exists. In 1931, 66 per cent of all hospital beds in the United States were under government control. Fifty per cent of all ward cases in New York City are now subsidized by the municipality and 40 per cent of the ambulatory cases are treated in city hospitals.

State medicine is not a system of medical education; it is a medical cooperative service for the benefit of the public, and all those desirous of working in the medical field should come thoroughly prepared to render efficient service. Medical, dental, and pharmaceutical schools should cooperate with the system so that the number of graduates can be curtailed or augmented as required. It will be necessary for these professional schools to alter their curricula from time to time so that the graduates will fit into new and expanding departments. It may be confidently expected that disease prevention, mental hygiene and psychiatry will derive a great impetus from such an organization.

Under state medicine, industrial accidents will automatically be divorced from employment insurance. This will result in substantial saving both to the employer and the state. The other benefits of the system, if it is efficiently conducted, cannot be estimated. By proper measures the morbidity and mortality of infants' and infectious diseases will certainly be reduced. The same applies to the hazards of maternity. The prevention and treatment of chronic diseases is a field that has hardly been scratched and considerable progress here may be expected when conducted under proper direction and management. The saving to the state and citizens may in the end be so great as to justify the system.

The cost of state medicine will not be as great as the present system. In 1929 the people of the United States paid for all kinds of medical service nearly three and three-quarter billion dollars. This included fees to doctors, dentists and nurses, hospital care, drugs, irregular practitioners, faith healers and patent medicines. The amount paid for irregular practitioners, faith healers and patent medicines alone was approximately $500,000,000. Because many of the services and equipment overlapped, a great deal more than necessary was expended. It has been estimated that every man, woman and child on the average paid for all kinds of medical services nearly $30 a year. A liberal estimate as to the legitimate amount that should have been paid may

be placed at $25 a year. If every person in the United States on the average were to pay this amount in addition to the regular taxes, it is felt that it would be sufficient to defray the expenses incident to state medicine. No provision is made, however, in this figure for the purchase of existing hospitals, equipment and the erection of new buildings.

The Endicott-Johnson Company, at its plant in New York state, provides 15,000 workers and their families with a well-rounded medical service including medicine, dentistry, nursing, hospitalization and drugs. In 1928 the cost was $25 per capita.

Out of the total amount expended for medical services by the people of the United States in 1929, doctors received on an average of $9,000 a year. About 40 per cent of this was allotted to overhead. With the inauguration of state medicine, this overhead will be eliminated, for doctors will not need private offices. All of their work would be done more efficiently in the medical centers of the system. It is felt in some quarters, therefore, that physicians working under the new system would receive on the average $7,000 annually net.

In medical practice as it is constituted today, doctors use both their professional and business talents for the purpose of making as much money as possible. It is a sad commentary on the present system that those who are rendering medical service should be compelled to exact fees, either large or small, from those who through no fault of their own are stricken with illness.

Many men in medicine have capitalized this to such an extent that they have become enriched. The talents of men in medicine under the proposed system will not be used for the purpose of making more than a comfortable living. The additional benefits which they will derive, however, will be respect of the community, enhanced professional standing and the pleasure and satisfaction of rendering service to the suffering.

Except for those desirous of paying the doctor directly, free choice of doctor will be lost. This, however, will not be a novelty. In accepting medical charity, over 70 per cent of the sick people have lost their privilege of selecting a doctor for the treatment of their ills. The physician has also relinquished, in part at least, his right of treating patients of his own choosing. In the wards and clinics of hospitals that right has been abrogated.

It has been said that under state medicine the urge for research and accomplishment in medical sciences will be stultified. Most of the discoveries and advancement in medicine have been made by men working on salaries in the laboratories or by clinicians employed on a full-time basis. It is likely that when the necessity of struggling for a livelihood has been eliminated, the urge for creative work will be lessened.

But there is another side to the question. Under state medicine, doctors will not become careless because their incomes and positions are guaranteed. The practice of medicine is no longer a one-man job. Except in self-limiting and minor ailments, laboratory work and consultations are necessary for the proper management of a case. In this

way, a certain amount of supervisory control is exercised even today. Under state medicine, the doctor could not afford to become careless, for his advancement in the system would thereby be put into jeopardy.

Politics will no doubt play a considerable role in the organization of state medicine. It is impossible to avoid it because of the many elements that serve to initiate and perpetuate the system. We are dependent upon legislators to vote for the proposal before it can have a beginning. It is common knowledge that our lawmakers will not encourage the enactment of a project for which large sums of money will be expended unless they can control the disbursements. But when the force of public opinion is sufficiently great these gentlemen will do its bidding irrespective of their personal interests. Politics exerts its influence in state education but neither the public nor the teachers are desirous of a return of private education for a majority of the people.

From now on the people of the United States must be on their guard that legislation be not enacted for changes in medical practice that will be inimical to their interests. In many states this year bills for this purpose will be presented for adoption by the legislative bodies. Many of them will be of a character that when made into law will act as mere palliatives and in the end will do harm rather than good. The public pays the bill and should get that which is for the good of a majority and not for a favored minority.

## SHALL IT BE STATE MEDICINE?

(Article by T. Swann Harding in the Christian Century, volume 52, pages 988-991, July 31, 1935.)

Dr. H. Clifford Loos (whose sister, Anita, discovered that "Gentlemen Prefer Blondes,") and his colleague, Dr. Donald E. Ross, have a remarkable medical clinic in Los Angeles. It is housed in a five-story building, it employs fifty-five physicians and twice that number of non-physicians, and it operates a complete ambulance service. It maintains doctors in twenty suburban towns and takes entire medical and surgical care of some fifty thousand people through the primary membership of fifteen thousand family heads.

The institution was established in 1929 and attention was first focused upon it by Dr. Ray Lyman Wilbur who commented upon the exceptionally low monetary rate at which the families of the members received the best of medical care. For the cost was but $2 per month per member, regardless of the size of the member's family. The institution has been operated on an ascending scale, it has become a community fixture, and numbers large groups of city employes among its members. It has the moral and often official support of every public service department in its county and other cities have invited it to extend its activities to them.

Here we have, then, a strictly modern and progressive medical group that has solved the economic problem of getting medical care to those who need it at rates they can pay. It seems really a model of what

privately organized (that is, non-state) medicine can do for the public health. Yet the local county medical association in 1934 took radical steps to curb this enterprise by charging Drs. Loos and Ross with fee-splitting, advertising, solicitation and, especially, with violating that section of the medical code forbidding physicians to dispose of their services under conditions that interfere with reasonable competition among the doctors of a community.

The county medical association then proceeded to dismiss these two doctors who, fortunately for the community, have sufficient financial resources to carry the fight further. Now the question of the license of these doctors to practice and of their competence was not involved. They sinned economically, if at all. Moreover, there are many ways in which their future, and that of their medical co-workers, will be menaced if this action of the county medical society is sustained. Whether it is sustained or not the incident offers laymen something to think about.

Moreover it is quite natural for us to conclude from such incidents, and this is but one of a succession of them, that American physicians are an avaricious, organized group of money grabbers who do not care how many people lack medical attention, and who resent the ability of any group to provide attention at a reasonable cost. This is untrue. For one thing the general run of physicians are kindly, charitable, humane men who work very hard and have uncertain and often inadequate incomes. But they do retain a powerful belief in obsolete economic dogmas. They may be communistic in their scientific activities, but they have to live their lives in a profit system wherein they are competitive economic individualists.

It has been shown very definitely that the medical organization of this country is deficient. We have sufficient equipment and an adequate number of doctors, dentists, specialists, nurses, and technicians. But the distribution of the equipment and the workers is so faulty, and medical and hospital treatment is financed by such unsound and even archaic methods, that the public is poorly served and overcharged—as a usual thing. Yet all this occurs without undue monetary profit to the average doctor. Why, then, do doctors in general prefer a system in which the rare few may by chance make a very large stake, rather than one wherein all medical workers would make comfortable, certain livings and the public would have the service it needs?

Over and over again it has also been demonstrated that isolated groups of doctors can organize institutions which will provide all the medical service needed by a large number of people, and make a financial success of the venture. This has been done by combining technical competence with good business judgment. Such things can be and are being done. Yet nearly every time a progressive group of doctors does this, and gives the venture sufficient publicity to attract patients, medical societies and associations made trouble for them on economic grounds. The position is taken that the doctor should vend his wares quite like any other merchant of the old school, as a strict individualist, and that the moment

he attempts to perfect an efficient organization for the distribution of his technic at lower than current rates, he has sinned against his brethren and should be cast out.

While it is true that state medicine for the indigent actually does not deprive the private physician of income, for he now serves paupers charitably and under state medicine he would receive some payment at least, the establishment by the state, or by privately organized groups, of clinics giving medical service at reduced rates does further menace the private doctor's income. The ground is slipping out from under the private physician all the time. His little private office and laboratory, with their equipment, are set up to enable him to practice medicine in such a way as cannot be sustained by terribly low fees.

Yet he sees various states passing industrial compensation acts which provide medical and surgical service for large classes of workers at low rates. He sees other large classes—the mentally ill, school children, firemen, policemen, war veterans, soldiers, sailors, the indigent, and certain public servants—become actual beneficiaries of what is practically state medicine. He then sees red. He declares that such service is incompetent, because rendered at a lower rate than he can afford to charge, and that the "coming" of state medicine is a socialistic or even bolshevistic menace.

Here he is wrong. We laymen know that we have in many cases got excellent service from public clinics. Medical treatment is not necessarily incompetent merely because it is reasonably priced; it may be reasonably priced simply because it is efficiently organized on an entirely different basis from the setup of the little individualistic private practitioner. Moreover, state medicine is not "coming"; it is already here. The state already has wide authority through its police powers in the matter of protecting the public health against bad drugs, impure foods, possible epidemics, and so forth. Moreover, it decides by its examinations who shall practice medicine.

More than that, about one-sixth of the families in New York state, exclusive of New York City, are right now receiving medical care through state aid. The government enforces comprehensive health laws for the prevention of disease; it provides treatment for mental disease through an expensive hospital system; it provides child guidance and infant and mother after-care in special clinics; it provides treatment for tuberculosis and crippled children, as well as for the construction and maintenance of general hospitals, the physical examination of school children and the correction of their defects. The state has also established a multitude of diagnostic laboratories; it treats victims of venereal disease, and it furnishes general medical care as a necessary adjunct to unemployment relief.

State medicine is here. It is here because of inherent defects in our economic system and because the functions of government vastly increase as a society becomes more populous and complex. There is also an ever-increasing number of proprietary clinics operating for profit but at low fees. There are other university and quasi-governmental

clinics that give service at cost. The private practitioner of medicine has been relieved first of his charity patients who have become wards of clinics at which he often appears and still treats them gratis. He is now having taken away from him a large group of middle class patients who can pay reasonable but not his seemingly exorbitant rates for competent medical service.

By the nature of his calling the doctor has had to be a humanitarian and the public has always too willingly accepted him as such. For we regularly expect our doctors to give freely of their time and attention to us, something we should never expect of lawyers, or even of trained nurses. Doctors have had to perform these charitable gestures as if they did not care at all for money. Yet they have lived in the same acquisitive society in which we live. They have had to struggle to attain the standards of living we expect of them. They have had to sell their technical ability in the market, right while their wage scale was being depressed by the advent of many new institutionalized agents of medical treatment.

It is easy enough for us to sit in condemnation of the doctors and to regard them as heartless and greedy. But they too have children who need shoes, wives who need clothes, and houses and equipment to keep in repair. They did not themselves order the mass changes in our economic system which render their own situation precarious. Quite naturally they tend to cling to old forms and customs which, in the past, gave them and their predecessors a decent living. But it is time that their leaders awakened to modern trends.

For one thing, the cost of medicine as at present subsidized has fallen heavily upon certain business and industrial interests. These interests naturally seek not only to depress the physician's income, when he works as a salaried employe, but also increasingly to adovcate forms of state medicine that will be disadvantageous for the doctor and hence bad for the public. They do this in part to distribute the cost of medical service more widely among the public, and then to relieve themselves of what they regard as an undue share of that cost, but also to saddle a lowered income upon the doctor by state decree.

The leaders of the medical profession have been blind to this tendency. They have failed to see that the provision of adequate medical service for all the public is a problem confronting both doctors and the public, and that unless doctors solve this problem, a solution unfair to them and hence, in the long run, unfair to the public may soon appear. That their own incomes on the private fee system tend toward extinction doctors tend to regard as a result of the pernicious activities of iniquitous individuals, who seek to undermine their position, rather than of the irresistible operation of economic laws.

Some years ago British doctors remained aloof from this problem and affected to disdain all forms of state medicine. They refused as a group to have anything to do with the scheme of national health insurance which was finally devised by laymen and put into operation. Because doctors had too little to do with its devising it was a most

imperfect system and it took years to solve the problems presented. Yet today the various British medical journals repeatedly praise the system of modified state medicine finally evolved in Great Britain and decry the American journals for misunderstanding and ridiculing it.

The project indeed was undertaken in Great Britain by conservatives who regarded it as a bulwark against socialism and state medicine! But today the British doctors almost unanimously unite in desiring the continuance and the improvement, not to say the further extension, of the insurance medical service which they say has produced immense gains for the community. They recognize themselves as part and parcel of the community as a whole, something the organized American medical profession has not so far done.

The provision of better medical care for the general public is paramount in this country. The American medical profession can only improve its own status by recognizing this problem and advancing its own interest by improving the status of the community as a whole. The experience of Great Britain and of many other countries offers guidance and shows that the doctors do not suffer injury in the long run, especially if they interest themselves in the scheme and take an active part in its formulation.

It has been shown by experience of other countries that it is better to provide not merely for doctor's visits, but for full medical service, right at the start. But the medical treatment side of such a system should be kept as separately as possible from the business of reimbursing the insured. There should be as little interference as possible with the relationships between doctors and their patients. Members of the medical profession should hold the high administrative positions in such a scheme and there can easily be arranged far more freedom of choice of doctors under a state scheme than under our present system of unorganized charity.

The doctors need have no apprehensions of disaster to the medical profession. The system would be advantageous to the public. The medical profession cannot and will not be obliterated. It will gain rather than lose dignity and prestige by taking an active, voluntary part in the complete reorganization of our medical facilities. It can, however, be injured by waiting for regimentation under hasty and ill-conceived lay-devised legislation. By formulating their own scheme now doctors can insure themselves a decent livelihood and end quackery at one and the same time. Moreover, they can freely utilize their expert knowledge for the social good at all times. They will not have to stop a course of treatment or advise some less adequate method of treatment because the patient cannot afford the best. Precisely the same funds we now expend on our inadequate and disorderly medical system will amply finance a soundly organized system of medical treatment for all of us.

It is all a matter of reorganization and rearrangement. The French offer a cue. The French medical profession did not sit supinely waiting till laymen handed it a scheme and forced it to accept. French doctors

clearly read the future. They then went to work diligently and fashioned their own scheme which the French public accepted under the health insurance laws of 1930. So effectively indeed did the French doctors combine, and so powerful was their threat of non-cooperation, that every one of their demands was granted. The resulting scheme may fairly be called a system of health insurance after the doctor's own heart which also admirably serves the public.

French medical men are grouped into local professional bodies called syndicates. These are united in a national federation representing 17,000 doctors. This federation massed, formulated and presented its demands, and drew the support of the dentists and pharmacists. But the public was assured that the doctors had no objection to national health insurance. What they objected to was the turning of patients into numbered cases and setting up of invidious distinctions between insured and other patients.

The scheme permits the patient absolute freedom of choice of doctor, dentist, pharmacist, midwife, masseur, and nurse. Things are so arranged that patients make direct payment of their fees to doctors when they are examined. The patient is later reimbursed by his insurance office at a set official rate or, if indigent, he can arrange an emergency grant of cash in advance. Professional secrecy is perfectly safeguarded. Doctors have complete control of prescriptions and of all medical matters. Laymen handle the funds.

Here is a medical system which strictly preserves the individualism within the frame of collectivism. The insured patient is made in all points the equal of the non-insured, no matter how wealthy the latter. The doctor does not know whether his patient is or is not an insurance beneficiary, until he fills out a blank before the patient leaves. Since his fee is the same in either case he does not care about this matter. Benefits are paid for sickness, maternity, old age—and eventually will be paid at death. Medical and dental care, as well as surgery, hospital charges, and drugs and appliances are all covered.

It does seem that American physicians have been downtrodden long enough. It is time for them to realize that bigoted belief in archaic economic dogmas will not profit them. They must take a hand in the formulation of their own destiny. They have made modern medicine what it is, for without the doctors there could be no clinics, no hospitals, no medical research—no matter how much money was spent. They should organize, formulate a rational, scientific scheme of providing medical care for all who need it. They should put this scheme into operation under their own supervision, not under that of bankers, industrialists, business men or other laymen.

Laymen should be represented in the organization, of course, just as also should be dentists, pharmacists, bacteriologists, chemists and social scientists, but properly trained experts, selected by test examinations, should be in command. Then physicians would no longer be required to be either greedy and acquisitive or to work against the best interests of the public. They would be neither overpaid nor enslaved. They would

have complete equipment and decent salaries, not to mention sick leave, medical attention, vacations, and fixed hours of leisure and recreation. They would retain permission to treat wealthier patients for fees. They would have retirement allowances and could be pensioned early enough in life to enjoy it if they wished.

In this scheme the basic relationship between doctor and patient would remain unchanged. We patients would have freer choice of doctors than ever before. But the detailed formulation of such a scheme is the job of physicians. It would be impudent for a layman to attempt that. However, any layman can see that now is the time for all good doctors to come to the aid of the public, because physicians can best serve their personal interests and improve their professional status by first serving their fellows to the best of their ability.

## MEDICINE'S GREATEST PROBLEM: THE NEED OF STATE MEDICINE

(Excerpts from an article by Gilbert W. Haigh in the American Journal of Sociology, volume 34, pages 507-515, November, 1928. Reprinted by permission of the University of Chicago Press.)

For some time the profession of medicine in this country has failed satisfactorily to serve its fellowmen. This failure is manifested by such baffling problems as the expensiveness of medical education, the unsatisfactory rural medical service, the gradual extinction of the general practitioner, the only guiding and correlating agent in medical practice, the high cost of diagnosis and treatment for the middle class, the increase in numbers and influence of the cultists, and the need for more school and other public health physicians and nurses. The failure of medicine adequately to serve mankind, furthermore, is graphically shown by the recent report of statistics revealing the strikingly small proportion of several thousand people of different classes who, when ill, seek advice from the regular profession of medicine, namely, a mere 6 per cent. Though it is several years since an eminent teacher and practitioner of medicine in a lay periodical demonstrated that the middle class was not receiving commensurate benefit from scientific medicine, nothing has been done by the profession but to establish a few pay consultation clinics in the larger medical centers. For few, if any, of the numerous economic medical problems have any practical solutions been discovered, because they are merely corrollaries of the fundamental problem, which is the need of a complete organization for the unification and correlation of the growing and multiplying specialties of preventive and curative medicine.

Now these specialties are simply the inevitable outgrowths of scientific medicine, which from necessity, on account of its increasing scope and profundity, employs the economic principle of the division of labor. This obviously presupposes cooperation. Cooperation requires organization, which becomes increasingly more complex and extensive the more numerous the divisions of labor. In medicine, organization for render-

ing efficient service has not kept pace with the progress of the medical sciences. Industrial and public service corporations today endeavor to furnish complete service in their respective fields. Their expansion is checked by antitrust legislation only when competition is flagrantly suppressed. Today there is less restraint upon big business than formerly because of its efficiency and economy. Henry Ford predicts bigger businesses. Service is the slogan not only of the manufacturer but also of the merchant and banker. In order to improve its service the telephone company strives to instill into its employes ethical practices which read like those of a professional code of ethics. Since the custodianship of the health of man is far more important than the manufacture and distribution of commodities or of the public utilities, these elementary economic principles should be recognized as applicable to modern medicine in its present chaotic state.

While the necessity for the reform of medical practice remains unheeded, what is the inevitable tendency of medical practice? It is the expansion and multiplication of the various public health departments. For in the whole realm of medicine there are in theory two complementary divisions: preventive medicine and curative medicine. The former waxes as the latter wanes; in fact, at the very expense of the latter. Mathematically, the former approaches infinity, while the latter approaches zero. Already preventive medicine has acquired such momentum in its encroachment upon curative medicine that in practice no sharp line of demarcation can be drawn, on the one hand, between personal and public hygiene, and, on the other, between hygiene and medicine. Then why has not health in general become a public problem? It is acknowledged nowadays, when the layman recognizes the importance of hygiene and evinces unprecedented interest in the discoveries of medicine, to be more essential than education, which, with the progress of civilization, has become an undisputed public matter. Under our present competitive system of private practice the mortality of diphtheria was not materially reduced for at least ten years, partly on account of the failure of the individual physician to recognize the disease promptly and partly on account of the parent of the patient avoiding the expense of hiring a physician to attend him when not ill enough to be confined to bed. Recently such a patient, whose parents did not consider him to be sick enough during the preceding seven or eight days to require a doctor, walked into my office so septic that he was dead within twelve hours. The failure of medicine in its present disorganized condition satisfactorily to serve bears testimony that the time has come when it must be regarded as a public question in need of complete organization.

Under state medicine most, if not all, of the baffling economic problems of medicine would vanish. The graduate of the medical school would immediately become a member of the organization, serving several years as an interne with pay. This would reduce the expensiveness of his education and afford him the advantages of earlier marriage, and should stimulate his interest in his duties. Specialists only after suf-

ficient general experience would be thoroughly trained, so as to insure a high standard. Our hospitals could be organized in a rational way, with the out-patients' departments, where disease can be detected in its incipiency, properly coordinated with the hospitals proper and designed to provide home treatment through their staff members.

The present need for the independent expansion of such different public health agencies as tuberculosis clinics, school clinics, and charities, which are ever widening their scope, would be eliminated by the centralization of the health service of the communities. These various agencies would have access to the general health records in which they might be interested. They would not have to seek their cases, but would have them referred to them. They would cooperate instead of working independently. They would be so interrelated as to increase efficiency. The employes of many philanthropic societies would not, as at present, be permitted to render medical service in violation, not only of medical ethics, but also of medical practice acts. Many of the nurses the profession has trained are now illegally engaged in the practice of medicine because they are not lawfully responsible even indirectly to any qualified person or agent. The abuse of medical charities would be stopped. Many a self-respecting American widow, with a meager income, has been charged a fee of several hundred dollars to compensate the surgeon for nine or more such operations he has performed upon alien charity patients, many of whom intentionally conceal their financial assets beneath their working clothes and their feigned ignorance of the English language. Though, in general, the honest has to pay for the dishonest, when the proportion is so unreasonable that he pays ten times the amount of an equitable fee because nine patients pay nothing, he is carrying an unfair burden of which state medicine alone can relieve him.

The elimination of the private fee, moreover, would relieve the profession of an annoying, prejudicing, and distracting necessity of the present system of practice. Not infrequently has the difference in the fee obtainable influenced the expert either in his testimony before a court or in his decision to perform an unwarranted operation, to which the patient has acquiesced too readily because of his impatience or his desire to undergo an operation regarded as fashionable. General adoption of the financial methods advocated by some of the most successful physicians and surgeons would make of our profession a mere business. And yet, under the present changing conditions of private practice, it would seem soon to be necessary. Under fully organized medicine other problems arising from the inadequate and antiquated system of individualistic practice of medicine would also disappear.

But, under such an organization, how can the present standard and the future progress of medicine be assured? For are they not dependent upon the initiative of the individual? The assumed destruction of initiative by fully organized medicine is accepted by the older and more conservative doctors as an irrefutable reason for rendering state medicine not only untenable, but even unthinkable. My answer is, first,

that initiative is like a two-edged sword. Among professional men, especially, it must be controlled by a sense of honor and justice; it may make of one a quack, of another a scientist, according to his moral qualities. At any rate, the times and customs have so changed that many of the most reputable members are now engaged in either private or public contract practice. In the past most contract practice has been cheap and degrading. Those engaged in it have often been tempted to neglect it for their private practices. Today much is full time and profitable, and even inspiring. For some time, in fact, has not all real advancement in medicine come from our research laboratories, manned by a salaried personnel?

Furthermore, since 1906, the American Medical Association has so esteemed the ability of the commissioned medical officers of the army, navy, and public health service as automatically to admit them to fellowship. Their standard is thereby acknowledged to be on an average higher than that of civilian practitioners, who cannot qualify for fellowship unconditionally. Since only representative members of the profession enter these services, it must be admitted that the organizations themselves maintain and foster a standard higher than that of competitive medicine. In general, in an advanced period of civilization, the more useful member of society is not he who exercises his aggressiveness and independence, but he who fits into an organization which insures cooperation by means of its systems for guidance and control and stimulates personal effort by means of discipline and reward by promotion. The spirit of cooperation and service of our large corporations reaches even to the lowest employe. How much more efficient should be a complete organization of professional men! Why, then, should state medicine continue any longer to be rejected as untenable and utopian?

The second objection to it, its alleged prohibitive expense, does not any more justly warrant its summary condemnation. Imagine the present total expenditure upon the health of our commonwealth by recalling the various independent public and private health agencies in operation in any average community; the local board of health and the health department of the schools; representatives of the various divisions of the public health department of the commonwealth, embracing contagious, mental, nervous, and industrial diseases and child and maternal hygiene, besides some of the federal bureaus duplicating the state work; state accident boards for workmen's compensation; private and municipal clinics and hospitals, besides industrial clinics and hospitals; police surgeons manning municipal ambulances; health centers of different kinds; Red Cross workers; insurance and fraternal examinations; commercial laboratories, gymnasiums, and institutes for health examinations; in addition, regular and irregular practitioners among the medical and nursing profession, quacks, and abortionists; and finally, pharmacists and distributors of patent medicines and herbs. It must be prodigious. Does not this very multiplicity of independent health agencies denote waste and inefficiency? Would not the total cost of these actually be reduced by the complete organization of medi-

cine? The inefficiency and expensiveness of the service rendered even by reputable physicians and surgeons is testified to by substantially the same story of not a few hospital patients: to-wit, that they have in vain sought relief from different physicians during the past year or two, during which they have been partly or wholly incapacitated from work, and have spent all their savings, never having received an examination as thorough or as fruitful as a fourth-year medical student could make, or the benefit of a single consultation. Surely a patient unable to work is entitled to intensive study of his condition. State organizations only, by guaranteeing cooperation both on the part of the physicians and upon the part of the patients, would eliminate much of this loss of health, time, money, and life. Moreover, as insurance companies, employers of labor, school authorities, public health personnel, and social service workers could obtain all needed medical information from official services, it would be unnecessary to make the repeated superficial and hasty examinations for which fees or salaries are now paid. Accident boards and judicial courts, in general, could be saved much expense at present indispensable for ascertaining the medical facts of a case. Compared with these expenditures of unorganized medicine the cost of organized medicine would prove to be insignificant.

To illustrate the failure of the present competitive practice of medicine, I will cite two cases. Recently I was consulted by a patient who had been incapacitated for work for six months with what he called lung trouble, dating from an attack of influenza three years before. For several months he had just wandered from one reputable physician to another without relief. Being unintelligent, he gave none of them an opportunity to arrive at a correct diagnosis for two reasons: his case required more intensive or extended study than he permitted anyone to make; and he sought independent opinions of each succeeding physician without a conference of any of them. Finally, he resorted to an irregular practitioner who treated him for bronchitis with an apparatus, previously proved by impartial and disinterested scientists to be a preposterous humbug. After having paid four hundred dollars without any improvement, having no faith in the regular profession, he misspent several hundred dollars more for treatment with another apparatus. Now a simple examination disclosed evidence of heart failure. The cause was found to be a severe attack of rheumatic fever twenty years before, when his heart was known to have been damaged. Appropriate treatment restored him to such health that he was able to resume his occupation as bench worker within a few weeks. This man was allowed to spend all his savings largely because of the lack of cooperation of reputable physicians.

Then again, the experience of an intelligent school teacher is illustrative. She was advised by one of the leading surgeons in a large city to have her appendix removed. Before submitting to such an operation she determined to consult a prominent surgeon of a larger city. The latter, even though he admitted that the former was of excellent

repute, decided that an operation was not indicated. When in the course of several months her symptoms recurred, having lost confidence in the regular profession, she sought advice from a member of a medical cult founded entirely upon a single fantastic theory. In a short time her symptoms became so exacerbated that she was fortunate in surviving an emergency operation for a ruptured appendix. Here again a patient upon whose case the surgeons should have conferred lost faith in the regular profession and strayed away to a theorist. Such misfortunes can be prevented only by completely organized medicine.

In this plea for fully organized medical practice an effort is made to prove that modern medicine, which on account of its comprehensiveness must depend upon the economic principle of the division of labor, demands cooperation from both doctors and patients; that as the average layman today is cognizant of the fact that health is more important than education, and as the inevitable tendency is the growth of the numerous incoordinate public and semi-public health agencies, which have disrupted private practice, the time has come when we should recognize the need of a radical change from our antiquated system of individualistic medicine. Furthermore, it has been shown that fully organized medicine would dispel most, if not all, of the numerous baffling economic problems of competitive medical practice. Finally, state medicine has been demonstrated to possess two additional advantages, namely, the education of the people, both individually and collectively, upon pertinent medical subjects at appropriate times, and the eradication of the cultists and illegal practitioners. If, therefore, public medicine not only should be needed, but even may be inevitably evolving from our public health systems, both laymen and physicians must rouse and bestir themselves earnestly and deliberately to attack this greatest problem of modern medicine—the creation of a complete system of state medicine.

## STATE MEDICINE

(Excerpts from an address by James B. Bullitt at the annual session of the Mississippi State Medical Association held at Jackson on May 12, 1931, as carried in the New Orleans Medical and Surgical Journal, volume 84, pages 227-233, October, 1931.)

The situation is unsatisfactory. The doctor is underpaid; the patient is overburdened with debt and is often inadequately served. And yet modern medical knowledge offers marvelous possibilities of accomplishment. "Social sagacity has not kept pace with scientific and material progress." How can we coordinate supply and demand and distribution? If we accept the aphorisms that "the health of the people is the greatest of national assets" and that "the public health is the first duty of the statesman," then it follows that the best of sanitation, the best of personal hygiene and the best of medical care in illness should be available to every citizen. As a corollary to this we may add that the community should bear the burden of cost, not as a charity but as a

public investment. Community interests and human sympathy alike demand that the healthy bear a part of the load of the sick, that the wealthy carry a part of the burden of the poor. How can this be done without offending that fine sense of independence that constitutes the most valued possession of a free people? Shall we attain the desired end through sickness insurance or state medicine or some other form of socialistic effort?

We take pride in our intense individualism. This is the natural accompaniment of a strong, aggressive and independent spirit. We love to speak of the inalienable right to life, liberty and the pursuit of happiness; and we sometimes think that this means pure individualism. When we utter that great phrase, however, we should follow it with the later phrase concerning government of the people, for the people, by the people. To most of us the mere word socialism is anathema. The term is apt to bring to our minds a wild eyed soap box orator who would rather talk than work, or an ignorant and inefficient workman envious of his more capable fellows, or perhaps a parlor theorist who evolves impractical Utopias in the seclusion of his study. We need not waste our time thinking of such people. There are others of a saner and more philosophical bent who preach a gradual, but ultimately extreme, extension of governmental agencies. With them we can agree in many general principles, though we may differ as to the extent to which the process can and should be carried.

In a very real sense every law abiding citizen of a civilized country is a socialist. We differ only in a degree.

In a primitive society every individual, or at least every family, is self-contained. His shelter, his clothing, his food, everything he uses is "home-made." He may live with the tribe for protection or for gratification of his gregarious instincts, but he can separate from his fellow men and still live with but little change in his material comfort. Some simple commerce may be conducted and some simple government may exist, but in general an extreme individualism may obtain. In modern civilization the individual is not lost; his efficiency is still of the utmost importance, but his efforts must be coordinated with those of others. He is one of the threads in a closely woven fabric of society. His whole life depends upon others. Today not one of us could feed or clothe or shelter himself alone, much less obtain the multitude of other things that have become necessities. Life would be unendurable, if not actually imposible, without extensive organization of every sort of business and extensive restraint or control of these by governmental agencies. This applies in some measure to almost every field of activity. This is really socialism. Unconsciously we have come to approve of much that in former years we denounced. Our postal service, our public school system, our public sanitation, our medical practice acts are a few familiar examples. Within the memory of some of us, certainly within the memory of our fathers, each of these things was considered dangerously radical. The real question is not "whether" but how far and how fast we must socialize.

In medicine our greatest achievements have been in the prevention of disease. Most of this has been through a socialistic application of scientific knowledge. Individuals have pointed the way, but it is public organization that has banished yellow fever from our land, has halted the spread of bubonic plague, has brought typhoid fever to the vanishing point over wide areas, and has accomplished countless other benefits of which we all approve.

Is it necessary or is it expedient to apply this principle to curative medicine? Our individual interests as physicians must be subordinated to the real needs and welfare of the public. A partial application is of ancient and honored usage. Free hospitals were in existence two thousand years ago. No well conducted hospital can be supported upon the fees that the poor, the near-poor and the people of moderate means can afford to pay. In the past few years our public hospitals have increased astonishingly, and over 60 per cent of the beds are supported by public funds, national, state, or municipal, and many more are maintained by private philanthropy. It is hardly possible to estimate the benefits these confer on the public, but still the needs are far from filled. Country districts and small communities are almost barren of hospital service. These institutions are both a benefit and a detriment to the doctors. They afford us facilities for work that we could not otherwise obtain, but they also call for much unpaid service from us.

The trend in every civilized country is against strict individualism in medical practice. It may astonish you, for it certainly astonished me, to learn that in Germany today only 5 per cent of the physicians are in genuine private practice; 95 per cent receive their remuneration from the state or the universities or the hospitals or the insurance organizations. In Denmark and Holland sickness insurance, closely directed by the state, dominates practice. In England the panel system is steadily gaining strength, and the British Medical Association is changing from opposition to support of that plan. In this country the movement is evidenced by the steadily increasing scope of board of health activities, by the establishment of pay clinics, by the development of local health associations, and by the growth of medical services in large industrial organizations. These changes have come in response to genuine needs, but they do not fully or properly meet those needs. They do not reach all the people who need them; they are often inefficient, sometimes actually dangerous; the various activities are not coordinated and never can be coordinated under the present methods of their development; they lack the professional guidance that we might have given them but have withheld. The movement will continue to grow. It is both to our interest and to that of the public that we aid in formulating a comprehensive plan that will give the best possible medical service and will do justice to all.

Ideals are rarely attainable, but high accomplishment is only possible with high ideals as our goal. Let us try to draw, in outline, a picture of an ideal socialistic medical service, available to all, designed primarily for the patient, but just also to the physician. It must be in accord

with the spirit of organization that is the ruling force in our highly complex social structure. Private organization may be more efficient in business management than a governmental bureau, but that efficiency is for the benefit of the few, not for the benefit of the many. Most of the claims for that efficiency come from those who wish to make the profit. Private organization in medical matters will not reach all the people, nor can it operate all the different phases of medical affairs, nor coordinate the different kinds of service. This system must be conducted by or at least extensively controlled and directed by state agencies.

The maintenance of health depends upon personal hygiene, public sanitation and curative medicine. Our existing knowledge is sufficient to yield wonderful results, but only at tremendous expense. This cannot be met individually by those in need but can be easily paid by the public collectively. In our ideal plan hospitals and laboratories, adequate to the needs and accessible to the people of each community, would be developed at public expense. Medical men, trained at public expense and maintained by public funds, would be distributed through these hospitals according to the needs of the population. Consultants and specialists, drawn from the more experienced and more skillful men, would be stationed at strategic points. Among this corps of specialists would be an adequate number charged with sanitary administration. Opportunities for graduate study would be afforded, and utilization of such opportunities would be required. Periodic examinations for promotion and for continuance in the service would eliminate the unfit and indolent. Remuneration might be upon a fee basis, but probably salaries would be more practicable. The whole service would be free to the public. The organization and direction would be under the charge of medical men.

No ban would be placed upon private practitioners, but both they and their private hospitals would be required to measure up to the official standards. The bulk of the people would be well cared for and would be well satisfied with the public service, but there would probably always be a wealthy group who would prefer the independent practitioner whose value they would gauge by the size of his fees. Medical aspirants for this class would not be lacking; but with the gradual perfecting of the public organization this group would become progressively smaller.

Why should we object to such a plan? Behind all human actions there always lies a mixture of good and bad, selfish and unselfish motives. Many have a serious fear that the quality of our work would deteriorate, but in all our discussions on this subject the element of self-interest looms large. In our development from ancient days we have gathered a great tradition of altruism, of unselfish service to humanity without the thought of personal gain. We give more free service than any other class of men, not because we are better than they, but because we are bound by our tradition and because our work brings us in constant contact with human misery. We usually do this cheerfully (and boastfully), but we often complain of the injustice

of the burden and would gladly ease our tired shoulders. We are justly proud of our noble inheritance, but we must not forget that we also have a legacy of cant and conceit and conservatism. We almost believe in a divine rights of doctors. We evince this in our constant self-praise, in our sensitive resentment of criticism, in our indignation at any encroachment upon our prerogatives. We sometimes mistake the pale glow of tradition or the blinding glare of success for the clear light of ideals. To the highly successful physician with a large and lucrative practice, the thought of a mere salary is naturally not appealing. The indolent doctor who has ceased study and whose practice depends upon his personality and upon the medical ignorance of the public resents interference with his inactivity. Most of us are in neither of those classes, but we are borne down by the inertia of conservatism; we cling to our desires for independence, and we fear a lowering of our economic status. Probably it is because of these fears and prejudices that we are prone to believe that state medicine would destroy research initiative and would lower professional standards. Undoubtedly competition is a great incentive to effort, but this need not be lacking in a salaried profession. Honest and ambitious men work as faithfully and effectively for salaries as for independent fees. The work itself is the real stimulus; moreover, freedom from the harassing uncertainties of collections permits more wholehearted devotion to professional studies. The greater part of today's medical research and much of the finest clinical work is done by salaried men. Is it necessary to cite in evidence such organizations as the Mayo clinic and the Rockefeller foundation and many other lesser bodies? Or need we mention such individual names as Pasteur and Welch and Gorgas and Reed and hosts of others? The fear of lowered efficiency is unfounded.

Our fears that we should be reduced to penury have a scanty basis. The large incomes of the few would be much reduced. The pitifully small incomes of many would be increased. The great majority of us would probably stand financially about as we do today, and we would have a greater feeling of security. We would certainly be in a far better position under state medicine than we would be in contract jobs for privately controlled sickness insurance companies or industrial corporations. These promise to dominate the situation unless the state takes the field.

The serious problem before us is not whether there shall be a change in our medical system. That is assured. The real question is what form shall the new organization take, how rapidly shall it be developed, and who shall be its organizers. This calls for careful planning by our best minds and for a strenuous campaign by our most energetic leaders. The challenge is before us. How will organized medicine meet it?

My personal taste is strong for the old regime. I believe that it is true of most of us, but the public's will cannot be denied. Some form of socialized medicine is inevitable. Without the wisest guidance it may bring medical chaos for the public and industrial slavery for us.

We are at a fork of the road. We and the public are inseparably bound together. We must take the same route. Shall we be like Alice in Wonderland and say that we do not know nor care which way we go? If so, the public may draw us to destruction. The great movement has gained momentum. We cannot check it, but we may direct its course. Let us not justify the charge that we are "like a cross dog on a door step, basking in the light of our tradition and snapping at every passing shadow." The old order is passing away. Let us greet the new order with cheerful courage and faith, and let us take the lead in guiding it along the best and safest paths into the portals of the new day.

## MEDICAL SERVICE AT PUBLIC EXPENSE

(Excerpts from an article by Joseph Slavit in the National University Extension Association's Debate Handbook for 1935-36, pages 57-112.)

All the difficulties and defects, the limitations and failures of medical service today flow from one fundamental source and cause: the essential method of providing medical care and service. Medical care today is essentially a commodity to be sold and bought, and the method of purchasing it and paying for it is the crux of the situation. Medical care is sold, bought, and paid for on the basis of the private and individual contract, in other words, private purchase and payment, and the receiving of fees and charges for individual services rendered. The provision of medical care is presumed to be the individual responsibility of the citizen, and each one is presumed to provide and pay for his own medical care (and that of his dependents). Society or the community or government has but little active interest in the matter, except when it is compelled to intervene by unavoidable circumstances and contrary to the prevailing theory. It is basically private medical service. It is not a social concern.

The private and personal payment for medical service, in the face of the increased cost of modern scientific service, on the one hand, and the increasing inability of the masses of the people to meet this cost, on the other hand, constitutes the essence of the problem of medical care and the basis for a sound solution of the problem. A basic solution of the problem, then, must call for the following requirements:

(1) It must eliminate the immediate economic and financial patient-physician and patient-institution relationship; (2) medical care and service must be made independent of individual and economic purchasing power or income level; (3) it must be universally and unconditionally available, i.e., to all persons at all times; (4) it must be free of all stigmata and disabilities, economic, social, or other, such as indigency, charity, occupation, class, etc.; (5) it must become a social (government or community) responsibility, and no longer an individual responsibility.

Public services at public expense are not impracticable or exceptional, but, on the contrary, are numerous and successful. Education, elementary, secondary, higher, occupational and professional (including even medical education), are familiar instances of such services. Protection

of property and person (police, courts, and fire), parks, libraries, recreational facilities, sanitation, water, gas, light and power supply, transportation and communication services, are some of the everyday familiar examples which are more or less closely comparable to proposed public medical services, and which are in actual and successful operation in this and many other countries.

The analogies between medicine and education (or even the other services) have been frequently drawn and denied. But the case for public medicine is even stronger than for education. Much private education exists today side by side with public education. There are good reasons for such academic freedom. The truth of the matter is that the differences between education and medicine are not sufficient to outweigh the similarities between public education and public medicine.

Education is a prolonged continuous process, beginning with the young child and continuing far into adult life, beginning with elementary and concluding with professional education. The educational process, its various stages, costs, etc., can be fairly accurately determined, predicted, and provided for by proper budgeting. There are practically no unknown elements or unforeseen emergencies. The consequences of inadequate education are undeniably of great individual and social concern; yet they are neither as immediate nor urgent nor as catastrophic to health and life as is illness. Mens sano corpore sano, is more than a mere aphorism, acknowledged by education itself.

Injury, illness and disability, on the other hand, are often sudden and acute, may become prolonged or permanent, may be fraught with serious dangers and result in most serious consequences, ending even in death. Illness is almost always unforeseen and unpredictable, its individual cost cannot be estimated, budgeted, or otherwise determined and assuredly met. The role of illness in the course of human life is anomalous and pathological; it is a contingency. Education, on the other hand, is a normal episode, a physiological social process. Its place in human life cannot be questioned. But the abnormal role of illness makes it the more serious and urgent a social problem. In addition, the inability of the individual to meet such a serious situation at all times with financial assurance, makes necessary the social sanction and subsidy of health care.

As for the analogy between medicine and other public services, it is often even closer. Medical care may be compared even better, perhaps, to such services as fire-protection and police-protection. The contingency character, the acute urgency, the serious destructiveness, and the preventive aspects of these services are not at all unlike those of illness. Yet they are universally recognized public services provided at public expense. Why should medical service be less?

It is clear that numerous services are provided today at public expense by local and state government; that they are practical and successful; and that medical service is, indeed, more urgent than, e.g., recreational facilities. It must be noted, furthermore, that all these services are provided today under the present social and economic system, and

that the reconstruction of the whole social order, as is often argued, preliminary to the reorganization of medicine on a social service basis, is not at all essential, however desirable such social reorganization may appear to be. This question of general social reorganization, however, does not fall within the proper limits of the present discussion.

But the practicability of public medical service is shown more strikingly by the further social fact that even in the domain of health and medical services, public health services are neither impractical nor exceptional, but, on the contrary, are numerous and successful all over the world, including these United States. Witness our local and state health departments; the city, county, state and federal hospitals and other medical institutions; the U. S. public health service; the medical care at public expense of veterans, crippled and disabled children, of tuberculosis, venereal diseases, mental and nervous diseases, contagions, poliomyelitis; the medical departments of the army, navy, and now the medical care of millions on relief. This in addition to the fact that most free or public wards in the private, voluntary hospitals are maintained or subsidized by public or government funds, out of city, county, or state treasuries. Next to the private expenditures by the people for health service—79 per cent, the governmental expenditures are the largest item—14 per cent, the philanthropic contributions of our voluntary institutions amounting to but 5 per cent. Despite the disproportionately small amount of governmental expenditures for all sanitary and medical services and care, two-thirds of all hospital beds are government owned or controlled.

A study of the hospitals and bed capacity under both private and government ownership, operation and control is most interesting here. Of all the hospitals in the United States, but 28 per cent were governmental, while 48 per cent had government-supported beds in private hospitals, and 24 per cent of the hospitals were strictly private and proprietary. But of the bed capacity of these hospitals, 66 per cent were governmentally owned and controlled, while 27 per cent were free in private hospitals, and but 7 per cent of the beds were strictly proprietary. On the other hand, of the patients themselves, in American hospitals, 30 per cent were treated in government beds, and 63 per cent were free patients in private hospitals generally paid for from public treasuries. In 1929, there were 892,000 beds in all hospitals in the United States with 726,766 daily patients. The two-thirds of these beds which were governmental were 88.9 per cent occupied, while the one-third private beds were but 65 per cent occupied. By 1933, the total number of beds in our hospitals had increased to 1,027,000 with 801,271 daily patients. Of this increase of about 120,000 beds, 112,000 were governmental, with 90.1 per cent occupied; while but 8,000 beds more were in non-governmental institutions, and but 54.6 per cent of the private beds were occupied. Little wonder that we have been hearing of late from the voluntary hospitals the wail for greater philanthropic support, the demand for increased subsidies from government treasuries, the threat to close their doors (which has actually occurred in some instances), the request of

a forty million dollar loan from the federal government for hospital purposes, and the spreading movement and group organization of hospital service insurance plans on the principles of voluntary group insurance. This latter movement has received the wide endorsement of national, state and local medical societies, inconsistent, of course, with their formerly declared opposition to health insurance and "all forms of socialized medicine." It should be noted particularly, in this connection, that almost half the private beds are unoccupied as against 90 per cent use of government beds, despite the need for medical care and hospital facilities. The extent of the actual expenditures by government for health purposes will be discussed in greater detail, when we shall consider the financial practicability of our proposal.

How is the cost to be met? How is the needed money to be raised? The fact is that four-fifths of the medical bill is paid privately, and that but one-seventh is covered by public funds today. How are the four-fifths or six-sevenths which are not met today by public funds to be raised? The obvious answer which at once comes to mind is—additional taxation. Taxation is the principal method of raising public moneys for general or special purposes. Whether such taxation should take the form of increased general, income, realty, inheritance, or other special forms, is a matter for public opinion, government, and tax-students to determine. But the general aim should be to avoid special methods and machinery for taxation, utilizing existing tax methods and agencies, and thus avoiding other causes of waste.

Suggestions of taxation always raise an outcry somewhere, and it is not within the scope of this article to discuss the pros and cons of taxation, except in a few general comments. Assuming an average increase of $30 per capita per annum in general taxation, it must be realized that there would at the same time be an average annual decrease of $30 per capita in the private expenditures of the people for medical care to which they are subject now. No important change has taken place in the cost of medical care by changing from private to public provision, but a most important advantage, to say the least, has occurred from this change of meeting costs which did not exist before, to-wit: the assurance of medical care for all at times. If to this can be added economies hitherto impossible, the change would prove profitable and could offset any possible increase in taxation over present actual medical expenditures.

The question of inequality and discrimination involved in taxation, in making some pay taxes for services which they might not receive and giving others services for which they may not pay taxes, is the same raised in the matter of education and other public services. The writer has never had a fire or a robbery, yet he has for years paid his quota of taxes which undoubtedly supported the police and fire departments. On the other hand, he has easily been compensated for this by the education he and his family received at public expense, or other services of an equally important nature. The whole philosophy underlying public service is the common or community need and not merely individual need.

## WHY STATE MEDICINE IS NECESSARY

(Excerpts from an article by Edgar Sydenstricker in the Forum and Century, volume 90, pages 47-51, July, 1933.)

One of the more ridiculous anomalies of the economic system which we call "American" has been brought to light in the recent reports of the committee on the costs of medical care and on medical education. This particular anomaly may be stated baldly thus:

There are about enough doctors, nurses, and others who render or assist in rendering medical services—about a million persons all told—to take care of all sicknesses and do nearly all the preventive work for individual patients that we now know how to do. There is being spent annually by the American people enough money—about three and a half billion dollars—for doctors, nurses, medicines, and all sorts of medical services, good and bad—to purchase reasonably adequate medical care at current average prices. Yet in a year's time—even in a prosperous era—thousands upon thousands of families cannot afford to obtain any medical care; millions upon millions of cases of sickness which ought to have medical attention are unattended; less than 7 per cent of the population have even a partial physical examination and less than 5 per cent are immunized against some disease; much preventable sickness occurs and the death rate among adults of middle age is increasing. Although medical science is still far from having solved all the mysteries of ill health, only a little of the knowledge already gained is applied to all the people needing it. A large proportion of doctors and others who apply this knowledge do not receive an adequate or even a decent living income and, with a deep sense of social duty, render much medical service without any pay.

This, it is being recognized more clearly than ever before, is not only a ridiculous anomaly but a shameful situation in which to find ourselves. Of course since 1929 we have grown somewhat accustomed to being ridiculous although unashamed. Nevertheless, according to a well established American belief, it is bad business if one doesn't get paid for what he sells, or doesn't get what he has bought and paid for. According to all canons of social well-being, of sound national policy, and of human justice, something is seriously wrong. It has been wrong a long time, for this situation existed even in our days of riotous prosperity.

The obvious conclusion from these statistics is that the great majority of American families do not get nearly the medical care they need because they cannot afford to pay for medical care when they need it.

Let us look at the picture from the doctor's point of view.

Such facts as are available show that in 1929 one-third of all physicians had net incomes of less than $2,500 and one-half less than $3,800. If we graded physicians in income intervals of $1,000, more physicians would be found in the $1,000-$2,000 class than in any other. And this was in 1929! Of course there were some with incomes of $10,000 or more and a few with $15,000 or more, but we are speaking of the ordinary doctors, in ordinary cities, towns, and country districts.

The obvious conclusion from these facts is that the doctors are not getting rich. That is putting it far too mildly, however. When we consider the investment in the doctor's training and his responsibility, the inescapable conclusion is that most medical care actually rendered is not being adequately paid for.

The underlying reasons for this situation may be fairly summed up in a brief statement of facts:

1. Medical care for nearly all of our population under the economic system which we have developed, is a service to be bought when needed. This means that most medical care is produced as an economic "good," has a price, and must be paid for in the market. Four-fifths of the producers are not salaried employes or wage earners; on the contrary they are professionally and expensively trained entrepreneurs who, within certain self-imposed "ethical" limitations, are engaged in business for profit. The greatest opportunity for profit, under existing conditions, is afforded by well-to-do purchasers and the competition for profit is active. The business is not profitable except to a few, because of the high cost of maintaining many competitive enterprises and because of two other conditions, namely:

2. Although fairly accurate predictions can be made as to when and how much of this service is needed by the people in mass, the incidence of sickness in any individual family during a given period of time cannot be foreseen. This means that medical care, especially the most costly care, is a service to be purchased by the individual family in emergencies.

3. Under the American economic system the distribution of purchasing power is so unequal that even in most prosperous years, and even if foresight and thrift were common characteristics of human beings, a very great majority of the individual families are unable to provide against these emergency needs for medical service.

The economic problem to be solved in the socially essential task of providing medical care to all of the people, thus narrows down to that of adequate payment of those who render reasonably efficient service under an economic system that postulates a grossly unequal distribution, in the population, of ability to pay.

The situation is one that calls for a definite program of action upon a large scale, especially in a period when the ill effects of industrial and agricultural maladjustments upon the health of many will be manifested. We are not dealing with a matter of minor importance. Nothing less is at stake than the public health itself which, as Disraeli said many years ago, "is the foundation upon which rest the happiness of the people and welfare of the state." The end of any effective attempt to solve the problem before us should be nothing less than to make it possible for every person to obtain such medical care as we now know how to render. This medical care should be provided and must be paid for.

If I were to outline even roughly such a program, I would say that its scope should not be less than state-wide, although its development in some localities may be slower than in others; that all kinds of medical

care, at home or in institutions, should be provided; and that those who receive this care should include not merely those who are employed but all persons and their families having incomes below an amount sufficient to purchase medical services in any contingency. We should go beyond the health insurance systems of Great Britain and Europe which provide financial assistance, and in some instances medical care also, to employed individuals only, and we should go further than to provide public medical service for infants, children, and mothers, or for tuberculosis and mental diseases. In such a program the maintenance of the physician's professional freedom is of cardinal importance; adequate remuneration of all who render medical service is necessary; and the promotion of higher quality of medical care, the professional administration of professional personnel and activities, the maintenance of the private relationship between physician and patient, and the patient's free choice of physician are obviously essential.

The committee on the costs of medical care came to the conclusion, quite rightly, that the costs of medical care should be placed on a "group payment basis through the use of insurance, through the use of taxation, or through the use of both." Insurance is a well-established procedure of distributing costs; taxation for maintenance of health is in accord with the thoroughly well-recognized principle, so succinctly expressed by Dr. William H. Welch, the beloved dean of American medicine, that "there is no more important function of government than the prevention of disease, the protection of the health of the people."

Yet, strangely enough, the terms "state medicine" and "compulsory health insurance" incite some to unreasoning fury. In facing a problem which concerns the health and happiness of the entire population, it is perhaps not impertinent to suggest that the time is come when we should cease to listen to any except those who are willing to think about the matter dispassionately, and, it might be added, unselfishly. For no one, unless he is hopelessly timorous or narrow-minded, should refuse to consider, frankly and without prejudice, any procedure, no matter how radical it may seem at first glance, which can be utilized in dealing with a social problem.

The distribution of the costs of medical care among that moiety of the population which is able, or partially able, to pay but cannot meet emergencies is clearly a situation to which the well-established methods of insurance ought to be applied by the government as sound business procedure. All experience points to the desirability of the compulsory form of insurance as well as to public control of its administration, including the collection of the insurance premiums. But the compulsory health insurance can only be a partial solution for several reasons. One is that the proportion of our population which is indigent or which is on an economic level so low as to preclude the payment of all of the insurance premiums, obviously cannot be provided for by the insurance method; this proportion varies greatly with the ebb and flow of "prosperity." Another reason is that there are many rural areas in which

not only many of the population are unable to pay insurance premiums but medical personnel and facilities are seriously lacking.

Furthermore, there are certain types of sickness for which the insurance method is not easily applicable. Communicable diseases, for example, properly are a menace to the public and their prevention as well as care properly constitute a public function. Tuberculosis, cancer, orthopedic defects, are matters not only for public concern but require expensive treatment far beyond the ability of the ordinary individual to meet or a strictly insurance system to provide for. Hence, recourse must be had to public sharing through taxation of some of the costs. In fact, taxation is already being relied upon more or less generally to meet: (a) all of the costs of medical care of the indigent and of residents of communities where private facilities and personnel are not available; (b) most of the costs of more expensive services rendered to the low-income classes; and (c) the costs of highly specialized treatments for certain types of cases and of preventive care against certain diseases. It is safe to predict that in the coming period of economic readjustment, these types of public medical service will be developed to an increasing extent. It is the logical solution of these particular problems, whether some of us like it or not.

Public medical service along these lines and compulsory insurance against the costs of other medical care are to be regarded as complementary parts of a state-wide system of paying for medical care. The rendering of medical services obviously must be done by physicians according to standards and in ways deemed by them to be most satisfactory and efficient, but the medical, nursing, and dental professions will fail in their duty unless they cooperate in developing a program whereby all of the population can be served and a situation be more adequately met—a situation which, to reiterate, is a ridiculous economic anomaly as well as a menace to public welfare.

## THE SOCIALIZATION OF MEDICINE

(Excerpts from an article by James Krimsky in the Nation, volume 123, pages 398-400, October 20, 1926.)

A topic of constant and serious discussion wherever medical men foregather is the prevalent and fast-growing abuse of dispensaries and hospitals by patients of means. Hospital authorities seek to impress their donors with the tremendous volume of work accomplished in their institutions and they do not bother seriously with investigating the financial status of their applicants. The patients follow the human instinct of getting something for nothing and the doctors fall over one another in the scramble for hospital and dispensary appointments. Meanwhile, as more and more new institutions are erected, the situation is becoming aggravated from year to year.

What is the remedy?

I have studied, talked, and written about this matter for years and I have come to the following conclusion: Hospitals and dispensaries must be redeemed from the thraldom of charity and placed on the

same basis as public schools, high schools and state-controlled universities. Institutional treatment of disease is becoming more and more the dominant factor in modern medicine. There we have the scientifically equipped laboratories, the splendid operating rooms, the costly and complicated X-ray and other equipment, the spacious and sanitary wards, the system and facilities of the modern clinic, the cooperation and team-work of the various special departments.

Take the rapidly spreading custom of undergoing periodic examinations as a means of preventing the insidious onset of disease. The wealthy patient runs the gantlet of internist, oculist, neurologist, X-rayologist, dentist, laryngologist, and other specialists; the pyramiding accumulation of bills works no hardship on his purse. The very poor patient goes to the clinic and gets the same series of examinations, frequently by the same or similar experts, and it does not cost him a penny. The middle-class patient, and he constitutes the vast bulk of our clientele, either sacrifices some of his bank account and is referred from specialist to specialist, paying as he goes along, or he sacrifices some of his self-respect and patronizes the charity clinic.

More and more as time goes on you find the middle-class citizen in the latter category. His answer is that private treatment, which today means treatment by different specialists, is getting beyond his means. Formerly his wife was delivered of her babies by the family doctor for a very moderate fee. Now she must have a specialist, an obstetrician, who charges a royal ransom. So she goes into the hospital ward and has her specialist for nothing or for a merely nominal fee, besides receiving the benefits of modern hospital care and highly trained nursing for herself and her new-born baby.

When the middle-class citizen was a boy he had his tonsils taken out by the old reliable family doctor for a mere pittance, but now Jimmy's tonsils and adenoids require the services of a specialist whose fee is a month's income. So Jimmy goes to the hospital, pays for a night's lodging, and the same specialist does the work for him and for fifteen other children in one afternoon without charging a cent.

The specialist is thrusting the family physician into desuetude. He is making him as obsolete as the one-hoss shay. But the specialist has had to pay heavily for his training. He has a high office-overhead. The private patient must pay for all that. The hospital patient in the ward pays a nominal fee or nothing. The dispensary patient, and his name is legion, pays nothing also. The private patient must foot the bill. The rich man does it easily, if not gladly. The salaried man, the pater familias of moderate income, the decent wage earner—they also do it until an unusually prolonged or serious illness, or a spell of unemployment or business depression or perhaps a strike drives them to the doors of the charity dispensary or hospital. After that they become regular patrons. They get the best service for nothing and no questions asked. So they send their friends and neighbors.

Cases like diphtheria, scarlet fever, measles, and other contagious diseases are best taken care of in hospitals. Operations, even of a minor nature, are coming to be performed almost exclusively in hos-

pitals. The field of the private office is being more and more encroached upon. The progress and development of medicine and surgery and the numerous specialties lay stress on preventive measures and accentuate the institutional study and treatment of disease.

It is almost impossible nowadays to make a scientific diagnosis without the aid of the bacteriological and serological laboratory to be found in every well-equipped hospital. If you go into a ward and study the chart of the average patient you will be astonished at the large number of special examination reports incorporated in that chart. There is the X-ray and the blood test and the urine analysis and numerous other microscopical and chemical examinations, not to mention the long line of specialists who have investigated the patient's heart, lungs, kidneys, liver, eyes, and so on. All that is essential in the modern scientific diagnosis and treatment of disease. And all that can best and most thoroughly be accomplished in the well-equipped hospital and clinic.

I return to my original premise. The hospital and clinic must be transferred from the realm of charity and placed under the control and support of the community. An objection will be raised that this will involve politics, that it will mean paternalism. It happens that the same objection is raised and the same cry is sounded whenever public and private interests clash. The end that I seek to advocate is the socialization of medical institutions which means ultimately and inevitably the socialization of medicine, the dedication of the medical profession to public service as an agency of the community, the members of the profession serving as public officials into whose care is intrusted not alone the cure of the sick but the far vaster function of teaching health, preventing disease, and guiding the community from childhood to advanced old age in the path of right and healthy living.

I am aware that my colleagues will oppose this plan. So did Canute oppose the onward sweep of the tide. You cannot check the rush of your patients to the clinics and hospitals. You are giving them better and more efficient service there than you can in your private offices.

Why not make the community pay you for your services in decent salaries rather than try to take it out of a rapidly dwindling private clientele? Is it beneath your dignity to be officers and employes of the public? Some of you are timid about the influence of politics on such a plan. An organized medical profession aiming at scientific advancement and having the public interests as its goal will always have the public backing against any sinister political influences.

Will such a plan entail material sacrifices on the part of the medical profession? Recently I received a confidential report of a physicians' loan society and I was appalled at the number of needy doctors who, after many years of active and faithful practice, found it necessary to apply for loans in order to tide themselves over financial difficulties. Another report gives startling figures on the number of applicants to a home for aged physicians. The average income of the average doctor is hardly anything to boast of. He surely does not shine in the income-tax reports. He would be far better off with a regular and assured

income, with the chance of promotion after certain periods of service, and with a comfortable pension on retirement.

The public health is the foundation underlying the happiness and power of the people. Every man, woman, and child, poor or rich, is entitled and should be free to secure the very best care and treatment that medical science can administer. I am my brother's keeper, and his illness, his incapacity affects me and affects the entire community in a hundred different ways.

What about the cost of this system of socialized medicine which I am advocating? Can the state shoulder the burden? Well, the state is paying much more dearly now. Figure it all up in dollars and health. Add up the millions spent on quackery, on tons of health-undermining patent medicines, the hosts of victims of preventable diseases or of diseases curable if nipped in the bud by timely and scientific diagnosis and treatment. Count up the cost of reduplication and waste in private practice, in charity drives and charity management.

Philanthropy in the field of medical practice has had its innings. It has rendered wonderful humanitarian work. It has created institutions of incalculable public value. It has brought us to the era of state control and state maintenance. The pasteurized milk stations started by a philanthropist years ago have now become the public health centers of the community.

So shall it be with the charity clinics and hospitals. They shall become public health centers dedicated to rich and poor alike for the maintenance of health and for the prevention and cure of disease. Today this will be decried as extremely radical. Twenty-five years hence it will be an orthodox creed.

## HOW EUROPEANS PAY SICKNESS BILLS

(Excerpts from an article by Michael M. Davis, in the Survey Graphic, volume 23, pages 617-19, 627-628, December, 1934.)

Germany began sickness-insurance legislation fifty-one years ago, building upon the long existent schemes of voluntary sickness insurance in the mines and railroads, systematizing and extending these schemes, requiring by law that these and some other workers come under sickness insurance and covering through the initial law some four million persons. The subsequent history of German sickness insurance is one of steady extension; first of the number of people brought within its scope and, second, in the range of the services provided.

In an American town everyone who is able to pay taxes pays some toward the support of the public-school system, whether he has any children at the schools or not. In Germany, under the compulsory sickness-insurance law, everyone who is employed (with exceptions for those with the higher incomes and certain other groups) must pay regularly into a sickness-insurance fund. Out of a population of about 62 million, some 20 million persons are insured under the compulsory law and belong to a sickness-insurance society, which is typically a local organization of all the insured persons living in a certain district. Into their fund the employers, as a rule, pay half as much as the

employes; the state pays nothing. While not technically governmental agencies; these sickness-insurance societies operate under regulations prescribed by law and by the administrative authorities.

The late Lee K. Frankel, a lifelong student of the subject, once remarked to me that the German sickness-insurance bodies were supervised by their government hardly more than is the Metropolitan Life Iusurance Company, an overstatement which still suggests a real point.

In addition, more than two million salaried public officials or civil servants are protected against the economic disasters of sickness and invalidism under the terms of their employment, and furthermore some two million middle-class people in Germany have voluntarily insured themselves against sickness with mutual commercial companies.

Under the German compulsory sickness-insurance law, a certain weekly sum, usually about half the worker's wages, is paid him for the support of himself and family while he is sick (usually up to twenty-six weeks). Medical care must also be furnished insured persons by their sickness-insurance society, and it may be provided in addition for the dependent members of their families. To establish such a family medical service the sickness-insurance societies must voluntarily assess themselves the additional costs, which will fall chiefly on the insured persons themselves. It is interesting that before family medical service was made compulsory in 1930 about nine-tenths of the sickness-insurance societies had provided it voluntarily for approximately 20 million dependents of their members.

Thus altogether about 44 million persons, or more than 70 per cent of the whole population of Germany, are entitled to receive medical care under some form of sickness insurance. At the top of the economic scale, the well-to-do pay for medical care by individual fees; at the other end, the destitute and those who have been unemployed for a long period, must have their care paid for out of taxes.

It is most important to realize that the physicians and surgeons of the public hospitals are mostly salaried hospital officers, although a few of them retain part of their time for private practice. The bulk of German medical practitioners have no direct connection with hospital services for either paying or non-paying patients.

For the forty-odd millions of persons in Germany who are within the scope of medical service under compulsory sickness insurance, it is probable that about half of the total costs of medical care is paid for by sickness insurance, 30 to 40 per cent by taxation, and the remainder by the patients, in the form of fees. The larger part of the payments from taxes is for hospital service.

Most of the sickness-insurance systems in European countries, except in Great Britain, France, and Russia, have been modeled largely upon the extensive German experience. In France, compulsory sickness insurance went into effect only four years ago. In addition to cash benefits which replace part of the wage loss during sickness, medical care is provided for insured persons and their dependents and includes some specialist and dental service. Under the French system a schedule of fees for professional services was established, of which the insurance

fund pays four-fifths or five-sixths, leaving the balance to be paid by the individual patient. These fee schedules are however generally lower than the rates which may be charged, and apparently often are charged, by physicians. The hospital system is supported mainly by taxes. Payments out of the insurance funds are made to hospitals for care rendered insured persons, but even in large cities these would not cover more than half of the hospital costs. It is probable that for the wage-earning population about half of the total costs of medical care is covered by insurance.

In Great Britain the national health-insurance law provides in addition to the usual cash benefit the services of general practitioners to the insured persons, who include all manual workers and other employed individuals earning not more than 250 pounds ($1,250) per year. This group constitutes a little more than one-third of the population. One-seventh of the cost of the plan is met by the state, the remaining being paid by the employer and employe, usually in equal shares. Some dentistry and some eye care have been added by the special action of some groups of the insured, but in general no care by specialists or in hospitals is furnished nor is provision made for service to the families. Thus for nearly two-thirds of the British people there is no provision for medical care through this insurance. The financial limitations of this will be evident when it is appreciated that if in the United States general practitioner services were provided to wage earners but excluded from their families, not more than one-third of the expenditures of our wage earners for medical care would be covered.

Hospital care has been put on a social-insurance basis in another way. The hospitals in Great Britain include about 170,000 beds, of which about 120,000 (more than two-thirds) are tax-supported. The remaining 50,000 beds are in the voluntary hospitals, which confine their work to acute cases. The government hospitals provide for practically all chronic cases and are taking an increasing proportion of acute conditions. These hospitals collect payments from patients who are able to pay, up to the cost of care. Their medical staffs are mostly salaried.

Taking the British system as a whole, and including both the compulsory and the voluntary insurance systems, it is apparent that only a part of the total cost of medical care is paid for by insurance, even for insured persons, and very little for the members of their families. The scope of medical care under British compulsory insurance has thus far been scaled down to a cost that could be met by the lower-paid wage earners and their employers, with some aid from the state.

In only one country in Europe does state medicine exist. Since the revolution Russia has put its medical services almost wholly under government management. Physicians and other professional persons serving the sick are government officers. Russian hospitals are government institutions. All expenses for medical care are paid out of special assessments levied upon industries or out of general tax funds. Physicians are entitled to carry on private practice, but private practice is in about the same relation to state practice as, in our country, private schools stand in comparison with the public schools.

# NEGATIVE REFERENCES

## MEDICINE AND THE MIDDLE CLASS

(Excerpts from an article by Wingate M. Johnson in the Atlantic Monthly, volume 147, pages 296-303, March, 1931.)

For a long time it has been open season the year around for doctors, especially those in private practice. No other class of public servants, not even the farmer, has had such a deluge of advice as to how to manage its affairs. The omniscient Arthur Brisbane is never so wise as when dispensing advice to the medical profession; as, for example, telling the best medical minds of Britain how to cure their sick ruler. In magazines so widely divergent in scope as the Atlantic Monthly, the Ladies' Home Journal, and Liberty, articles more or less critical of the profession have appeared. Most of these articles are written by non-medical men, perhaps for the same reason that old maids and childless couples are proverbially generous with advice upon the rearing of children. The doctors who contribute are apt to be biased by their connection with some governmental health agency, some medical organization more or less frankly commercialized, or some private charitable institution. These men bear about the same relation to the rank and file of the profession that the registrar of an agricultural college does to a real dirt farmer.

The excuses for attacking the medical profession are many; but the one used oftenest, and, indeed, linked with most of the others, is the alleged high cost of medical care to the middle class. It is recognized that the wealthy are able to pay for any medical service they want, and that the poor can get it for nothing, either at the expense of the state or from private charity; but for the middle class public sentiment is expressed by a recent writer in the Ladies' Home Journal: "the cost of medical care is unconscionably high." It is hard to say just why, with so many other high costs all classes—upper, middle, and lower—have to face, their medical bill should be singled out.

Compare the cost of medical care with some other expenditures of the average American family, which pays its doctors each year $24; for drugs and patent medicines (chiefly the latter), $25; for non-governmental hospitals, $15; and for nurses, $8. For passenger automobiles, this same hypothetical family spends annually $150; for tobacco, $67; for candy, $37; for gasoline, $37; for theaters and similar entertainment, $35; for soft drinks, ice cream, and chewing gum, $34.

In the light of the above figures, why should not those writers who wax emotional over the high cost of doctors plead with their Congressmen to lower the tobacco tax, or with candy manufacturers to make better and cheaper candy, or with a paternal government to supply its subjects with free gasoline for Sunday and holiday outings?

Undoubtedly, however, the cost of medical care has risen, though not out of proportion to the cost of living generally. There are many reasons which justify some increase in doctors' fees, of which perhaps the chief is the greater length and expense of medical education. The time has

passed when the only requisite for beginning the practice of medicine was the ambition to do so, fortified by a few months' apprenticeship to an older preceptor. Now a medical education represents the end of a long and expensive journey. Thanks to the commendable work of the American Medical Association, within this century the number of medical schools has been reduced by half, and only the fittest have survived. The public may be assured that a recent medical graduate is a picked man, with a thorough grounding in his profession. Furthermore, the education of the right sort of doctor has just begun when he is given his diploma. From one to five years more are spent in a hospital to gain practical experience. After this the man who aspires to keep up to date must subscribe to a number of medical journals, buy new books from time to time, attend medical meetings, take post-graduate courses, and spend considerable sums in new equipment.

Many a country doctor fifty years ago never owned a thermometer. One whose name was a household word in my boyhood would often say, "If I had a thermometer and a hypodermic syringe, I should be as well equipped for practicing medicine as any doctor could want to be." Contrast this equipment with the array now required even as a minimum for any man who aspires to be up to date. And books and instruments alike are subject to rapid obsolescence.

II

The chief reasons for the high medical bill of the middle class are usually ignored or touched upon very lightly. Being myself a member of the great middle class, I am vitally interested in its problems. Furthermore, as a physician in active practice since 1908, I have had the opportunity to make some observations which I hope are worth as much as are those of the laymen and non-practicing doctors who write most of the articles under discussion.

After long and careful pondering of the question, I am convinced that the people of the middle class have themselves to blame for the "unconscionably high" cost of their medical care. By accepting as axiomatic that the value of medical service is in direct proportion to its cost, they have certainly not discouraged medical men from charging all the traffic will bear. The multitude of people newly enriched by the prosperity following the war helped to strengthen this idea. By failing to discriminate between luxury and comfort, the cost of hospitalization is needlessly increased. By accepting without question the creed of the specialist, that the field of medicine is so vast that no one mind can hope to keep up with its progress, they have encouraged specialism and its offspring, group practice.

Let me elaborate the above statement somewhat. As an example of the first statement, a friend of mine who served his interneship in a New York hospital told me of a chorus girl who went to one of the best throat specialists in the city and asked his fee for removing her tonsils. Taking pity on her condition, he named the—for him—nominal sum of fifty dollars. She left his office without completing the arrange-

ments for the operation, and a few days later was operated upon by a far less able man who charged her a thousand dollars.

One of the most successful pediatricians in a large city told me that he was often called in consultation by a general practitioner in a neighboring suburb, who always insisted that he make his fee at least a hundred dollars. When he offered to reduce it in the case of an obviously poor family, he was reminded that unless he charged that much his advice would not carry any weight.

III

The main reason, however, for the plight of the middle class is their unthinking acceptance of that shibboleth of the specialist, "The practice of medicine has become so complex that no one mind can attempt to keep up with its progress." At first thought this sounds plausible, and it has certainly had its effect upon the attitude of the public toward its medical advisers. More than anything else, the universal appeal of this idea has encouraged the overgrowth of specialism. In turn the cost of medical care to the middle class has advanced in almost direct proportion to the increase of specialists.

The World War did much to accelerate the rise of specialism; but it had already begun its forward march before then. Other factors in its vogue have been the external pressure brought to bear by the increased prestige of specialization in business and industry, and by the restlessness and discontent of the general public, always anxious to try something new and different. Huge gifts from philanthropists, usually with knotty strings tied to them, have done much to encourage it. Even organizations within the profession have frankly encouraged men to specialize. Finally, the financial incentive to forsake the ranks of general practice for the easier and more lucrative life of a specialist tempts many.

Let me hasten to say that I have no quarrel with the real specialist. Our profession needs a balanced proportion of specialists of all sorts as well as of general practitioners.

The admission might as well be made, also, that when specialism first began its meteoric rise a majority of the men who limited their work were of superior intelligence; but this has not remained the case. The desertion from the ranks of general practice by so many of the best minds of medicine has caused the need to be felt for able men to fill the gaps thus made. Many others besides myself have tried the life of a specialist and found that it failed to satisfy their professional souls.

"Keeping abreast of medical progress" is not so difficult as the specialist would have us believe. As Dr. Crookshank said in a recent Forum, "A vast deal of rubbish has been written about the impossibility of any one man's grasping all the recent advances in medical science. I say 'rubbish,' because real science simplifies and does not confuse; it synthesizes and leads back to first principles, so that men of intelligence and judgment can with ease keep themselves abreast of the best opinion." As Dr. Logan Clendening has shown, the most important discoveries in medicine have vastly simplified the treatment of disease. For example,

the discovery of insulin has put the treatment of diabetes within the hands of any intelligent general practitioner. The treatment of pernicious anaemia has been reduced to the simple means of eating a half pound of liver daily, or of taking a concentrated liver extract. Vaccination against diptheria, typhoid, and smallpox can be done by any nurse.

## IV

Various suggestions have been made for reducing the cost of medical care for the middle class without retaining the family doctor. The most popular of these is group practice, in various forms, with some form of state medicine as second choice.

Group practice, as is well known, is the combination of a number of specialists into a medical firm or clinic. It might be defined as the department-store idea applied to the practice of medicine. Its advantages may be thus summarized: first, it assures, if properly conducted by competent men, a more thorough examination than can be given by one man alone; second—an advantage which may be also a disadvantage—a more impersonal view is taken of the patient; third, a doctor should certainly improve his technique by constant repetition of the same manoeuvres; fourth, with a number of men using a common reception room, laboratory, telephone, and otherwise dividing expenses, it is possible to give medical service at wholesale rather than retail rates—though not many patients who have been "through the mill" extol this feature!

The objections to group practice as a substitute for the individual doctor are: first, the average patient is subjected to an altogether needless expense, for only a small proportion of people who consult a doctor need an exhaustive examination to find out what is the matter with them; second, the impersonal view of the patient may lead to a lack of interest in his ailments; third, it is proverbial that a chain is no stronger than its weakest link, and the patient's trouble may lie within the province of the weak member of the firm; fourth, the view of a specialist is inevitably narrow, no matter how clear, and no aggregation of piecemeal observations can make up for a broad view of the whole organism; fifth, the patient is usually seen by each man once or twice, in a hurried examination, whereas every doctor of experience knows that the key to many obscure ailments, especially in the psychic realm, is to be found only after long, patient, and repeated interviews. Finally, if the diagnosis lies between a functional disorder and an organic lesion, it is hard for the most honest man not to yield to the subtle temptation to decide in favor of the organic trouble and advise operation, rather than launch upon the long and tedious course of psychotherapy necessary to uproot the more or less imaginary ailment. It is so spectacular to point an accusing finger at a curly appendix tip in an X-ray picture and tell an emaciated, overworked, high-strung little school teacher that her trouble is there, and that its removal will cause her to become strong, rosy-cheeked, and placid. Even if there is a lingering doubt in the mind of the group diagnostician, two thoughts will help to dispel it; the first, that even if the appendix is not badly diseased, the psychic effect of its re-

moval will do her good; the second, that he will not see her after she goes home, anyhow.

On the other hand, in the hurried examination often given, real trouble may be overlooked. Only last week a doctor friend of mine told me that two months ago he went to an important medical clinic for a complete physical examination. His tonsils had been inflamed several times the winter before, and he knew they still harbored infection. In his own language: "I have a perforation in my right eardrum you can put your fist through; the septum of my nose is as crooked as a rail fence; yet when I went through the nose and throat department both these were overlooked. They told me that my tonsils were all right until I told them of several recent attacks and called their attention to enlarged glands on both sides of my neck. Then they decided they had better come out." If a physician gets such short shrift as this, what can a mere layman expect?

The analogy is often forced between the individual doctor and the retail shopkeeper and small manufacturer. Because department stores are replacing retail shops, and mergers are absorbing small industries, it is assumed that medical firms or groups, or such huge medical mergers as the Mayo clinic, must drive out of business the individual doctor. The basic defect in this comparison is that doctors are dealing with human beings instead of machines; and human beings simply refuse to be standardized. The parts of one Ford car will fit a million other Fords; but no two human beings are just alike. To overlook the human equation and to attempt to treat people as animated machines is to invite failure.

## V

So-called part-pay clinics, in which medical service is to be obtained at reduced rates, have been suggested as a solution of the middle-class medical problem. Their expenses are to be borne either by the state or by private charity. In passing it may be observed that if the philanthropists who are given so much credit for their generosity in providing medical aid for the poor would raise their wage scale in keeping with their profits, there would be less need for such help. These clinics are open to the same objections as group practice in general, and, in addition, would have some of the objectionable features of state medicine.

State medicine may be defined as the assumption by the state or federal government of all responsibility for the health of its subjects. A most plausible argument for it appeared in a recent Atlantic Monthly, in which Russia was cited as a worthy example. This gives point to what Will Rogers said not long ago: "Russia is starving her own people in order to feed propaganda to the rest of the world."

Carried to its ultimate conclusion, there would be no physicians in private practice. All would be employed by the government and paid fixed salaries—probably varying according to their length of service. Various modifications have been suggested, such as compulsory health insurance, adopted years ago in England.

Theoretically much may be said for state medicine. Everybody would

have the privilege of consulting the physician of his choice, without thought of the cost. On the other hand, every doctor would be assured of a fixed income. All the financial burden would be distributed in taxes and paid according to the ability of the taxpayers. This, in the language of the street, sounds good. But let us consider some of the objections.

First, look at the effect upon the people themselves. In England, where compulsory health insurance has been in effect for years, since unemployment has increased, the number of certificates of illness has almost doubled. The doctors are placed in the embarrassing position of having to sign many certificates for faked illness or lose patients from their "panel" to those who will be accommodating enough to help their "patients" draw "sick benefits" from the government.

The right sort of doctor holds as his dearest possession his professional reputation. For many years after he begins practice his greatest ambition is to become known as an able and honorable physician; and the more firmly established his reputation becomes, the harder he strives to live up to it. One index of a doctor's professional standing is the number and the character of patients who come to him, and the proportion who remain loyal through the years. This does not mean that the best doctor always has the largest practice, or the reverse; for many other factors enter into the problem. It is only too true that a quack may so prostitute his knowledge of human nature as to attract a large following; but his practice is seldom a stable one. Dr. Axel Munthe has said, "you cannot be a good doctor without pity," and of pity the quack has none. Perhaps the best indication of a physician's real worth is the proportion of his patients who stick to him for many years. It is true that the stress of competition in private practice sometimes—nay, often—has developed heartburning jealousy among its members; but it has also brought forth their best efforts. And a much higher incentive than that of competition has been the trust imposed in the physician by his families. To merit their confidence, the right sort of doctor will make almost any sort of sacrifice.

Under state medicine, inevitably the old relation between doctor and patient would be destroyed. If the hypothetical John Smith only knew it, he would be exchanging an excellent birthright for a mess of very questionable pottage, were he to be a party to the socialization of medical practice. Instead of the wholehearted attention of a physician who is using every ounce of energy to give the highest medical skill possible, and who keeps his professional acumen at the keenest possible edge, he would most likely find the indifferent, devil-may-care attitude of the man whose reward is the same for much or for little effort; who has only to live long enough to attain the highest standing possible in his profession, and who cannot feel the pride in his work that the individual can. Imagine a doctor's being required to treat a certain number of patients per hour, regardless of what ails them, rather than to see how clever a diagnosis he can make in each individual case, whether simple enough to be dismissed in five minutes or complex enough to require his attention for an hour or more.

If the day ever does come when the state takes over the health of its subjects, individually as well as collectively—God pity the patients!

VI

The solution of the medical problem of the middle class is, after all, simple. It is for every family to select one physician for its medical advisor. This man should be selected with great care, and then trusted as long as he is found worthy of confidence. If the right sort of man is chosen, and knows that he is the absolute guardian of the family health and that he is expected to call in the help of a specialist or a group of specialists when he deems it necessary, he will put forth his best efforts to merit this confidence. His professional pride, combined with a personal interest in his patient, will make him more anxious to get results than any specialist would be.

The modern family doctor is not necessarily a general practitioner, in the sense that he undertakes personally to practice all branches of medicine. Indeed, the modern family doctor is apt to limit his work somewhat; but he keeps so well informed along all medical lines that he is capable of wisely directing those who trust him. Undoubtedly many patients with obscure ailments will be directed to individual specialists or to clinics; but the family doctor is abundantly able to take care of a great majority of the ailments that arise in his patients. Such a high authority as the committee on medical education of the American Medical Association has estimated that a capable general practitioner can care for from 80 to 90 per cent of the illness for which people consult doctors. The committee on the costs of medical care has found that the famous "upper respiratory infections"—colds, influenza, and their near relatives—alone constitute 62 per cent of the usual disabling illness, with the diseases of childhood and other common ailments to be added. Does this seem as though there were no more work for the family doctor?

The very conflict of opinions as to what is to be done to replace the family doctor argues for his continued existence. The very fact that no satisfactory way has been found to get along without him indicates that he is an essential part of the medical scheme. The medical man who is meant to be a family doctor can never be satisfied with any amount of success in another kind of work. In the present stage of medical evolution, this type of man is successfully adapting himself to his changing environment. While numerous lay and medical writers are penning more or less flattering obituaries of the old family doctor, the modern family doctor is busy making himself indispensable to as many families as he can serve.

## THE MEDICAL PROFESSION IS THE ONLY COMPETENT JUDGE OF MEDICAL SERVICES

(Excerpts from an article by R. G. Leland in the National University Extension Association's Debate Handbook for 1935-36, pages 113-136)

The debate question as stated involves an untried experiment on a national scale. It assumes impossible conditions. Such an experiment would

be a leap into the dark such as no nation has yet attempted. It calls for a sharp break in the line of evolution of American institutions. History has shown that attempts to make such breaks produce confusion and chaos in the beginning, and are in the long run destructive even of their own objectives.

No nation has ever attempted to provide a "system of complete medical service to all citizens at public expense." The United States did attempt to supply a partial service to indigents through the Federal Emergency Relief Administration. Its success has scarcely been such as to encourage its extension to the entire population. The plan of the affirmative would place all citizens in the class of indigents.

Soviet Russia is apparently the model it is proposed to follow, but at present Russia is not furnishing a "complete medical service to all citizens." Vast stretches of that country have practically no medical service. The best that is furnished in the industrial centers would be contemptuously rejected by American citizens. Yet the Russian system is but a part of the complete socialization of industry and of public services. To make medical service a first step in socialization in the midst of private industry would be to create constant conflict with every other phase of our society.

Those who advocate such a scheme seem to have been misled by some sort of an analogy with public education. Medical service and education really have little in common. Their methods of administration are widely different. Reasoning by analogy is proverbially dangerous. In this case it is positively misleading.

General education for all is a fundamental essential in democracy. An educated citizenry is demanded as protection for all of us. Illiterate voters are destructive to such a government as ours. Our system of industry demands educated workers. The laborer who cannot read instructions is a danger to himself and to his fellow workers.

Education can be classified, organized and delivered according to ages, grades of ability, subjects and in other ways. Education can be given to groups and classes. It is a necessity for nearly everyone, in much the same degree, at certain ages. The same textbooks and regulations may be used throughout wide sections of the population. Progress in education can be definitely measured. Standards may be set up and maintained.

Yet the sharpest criticism that is made of education today is that the necessities of universal mass education have created a harmful standardization. Educators are everywhere insisting on the need of more individual instruction. The strongest indictment brought against our educational system is that it treats all pupils alike—that it forces teachers and pupils into a common mold and seeks to run an entire population through a sort of standardized assembly line. It is charged that this destroys the power of independent thought—that it crushes the person of exceptional ability and thereby deprives the nation of much needed leaders. It is also charged that education is subject to the influence of politicians and pressure groups. It is claimed that these forces, ignorant of pedagogic methods, have made professional progress difficult and in some cases impossible.

Medical service is lacking in all the essentials that would fit it into a system like that used in education and the influences that have been most harmful in education would be more destructive if applied to medical service. There is nothing more individualistic than medical service. There is no uniformity of methods. The same diseases must be treated differently according to individuals. Every attempt to treat illness in groups and classes has destroyed the value of the service. Standardized methods, whether of appliances and drugs, or textbooks or lectures such as are used in education do not conform to the accepted practice in most fields of medical care.

Political control is especially dangerous when the mass of the people cannot judge requirements and results. There is at least a possibility of some degree of judgment in regard to education. Most of us can tell whether the common schools and the high schools are giving the pupils something of a knowledge of the subjects taught, but no patient, even though he be a physician, is capable of giving competent judgment as to the medical service he receives. That is why physicians do not treat themselves or their families. Even a physician, if he is to judge the quality of medical service, must be uninfluenced by the personal feelings and considerations which control the patient. It would be unnecessary to point out the foolishness of expecting citizens, untrained in medical matters, to pass intelligently on these subjects were it not for the fact that many of the criticisms that are being made of present service and the schemes for the transformation of that service assume that every one is capable of giving a competent judgment as to medical service.

Of course no one really believes that laymen are competent to judge such service. We prove this when an emergency arises. In time of war no one thinks of asking anyone outside the medical profession to provide care for the fighting forces. When an epidemic threatens, politicians and social workers are not relied on to stay its advance. When medical questions are at issue in the courts no judge will permit anyone but qualified physicians to testify regarding medical service. Yet every proposal to place medical service in the hands of the state or to have it operated under any system of compulsory sickness insurance or by other mass methods assumes, directly or indirectly, that laymen can judge and successfully control the giving of such service.

There has been no lack of partial forms of state medicine and there are places where this is permissible. The medical profession was among the first of those to urge the formation of national, state and local health departments. Medical associations generally are constantly working to improve and develop such departments. The important thing to recognize is that great as is the value of governmental health measures within their proper field, they become destructive of their very objective when they leave that field. Quarantine, inspection of food and drugs, disposal of sewage, safeguarding water supplies and whatever measures can be applied uniformly to the entire population belong in the field of public health. But the moment that these departments seek to furnish a "complete medical service for all citizens" experience has shown that the re-

sult is to destroy the most valuable characteristic of that service, viz., the quality of medical care. The result is, that instead of a "complete medical service" being provided, the existing medical service is restricted in its development, hampered in its progress and rendered inefficient in the care of the individual.

There is no way by which a government or an institution, per se, can practice medicine. Only individuals can receive the education, pass the examinations and, most important of all, enter into the individual confidential relations with the sick person which is the first step to the giving of helpful service. "Legislation" cannot provide a good "medical service." Laws that seek to compel physicians to provide such a service only succeed in destroying much of the value of the service.

More and more, as the medical profession progresses further into the secrets of sickness and disease does it become evident that a very essential quality of such service is the "will to get well" on the part of the patient, and that this "will to get well" depends on confidence in the physician. Another equally important ingredient in the provision of medical service is the enthusiastic devotion of the physician as expressed in his "will to heal." It is this quality of the physician which has always been the highest characteristic of the profession. It is this quality which entitles the profession to write into its principles of ethics the statement that, "When an epidemic prevails, a physician must continue his labors for the alleviation of suffering people, without regard to the risk of his own health or life or to financial returns." The history of the profession, in every nation, is filled with examples of individuals who have suffered disease and death themselves with never a thought of deserting their post of duty.

Idealism is an essential ingredient of medical service. Destroy it and you remove just that vital urge to thought and action that so often divides life and death in fighting disease. This devotion is not a part of the duty of the bureaucrat assigned to a political job. It is destroyed whenever the relations between the physician and the patient cease to be based on personal responsibility and confidence.

This situation is illustrated by another field in which state medicine has received its widest application in the United States. Workmen's compensation laws now exist in forty-five states. While these have fallen far short of fulfilling the expectations which were set forth at the time of their enactment, no one will deny that they have done much to secure greater justice in the treatment of workmen injured in industry. It will, however, usually be admitted that the most unsatisfactory feature of these laws has been the provisions for medical service. The control of this service was unfortunately left to lay organizations and political influence, and it was consequently administered much as it may be assumed that the sort of medical service proposed by the affirmative would be administered. The result was a series of abuses that have been condemned most energetically, not only by medical associations but by official investigators and even by administrators of the law. In some states wholesale corruption has made much of the medical care given more of a curse than a blessing to the injured workers.

Another form of standardized medicine, which exists in a large number of nations at the present time, and which is being urged for adoption in the United States, is compulsory sickness insurance.

In most of the nations where such systems of compulsory sickness insurance now exist, the conditions of medical service at the time of adoption were worse than ever would have been endured in the United States. In England, for example, medical care to low income classes was furnished very largely through "medical clubs" where the payments to physicians were so small and the number of patients to be treated so large that only the most farcical sort of care could be given. In Germany, prior to the adoption of compulsory sickness insurance, large sections of the working class population received almost no medical care at all, and the remainder were provided for under systems very closely resembling the club practice of England.

It is claimed that compulsory insurance has improved the medical care given to low-income classes. In many instances it would have been difficult for such systems to have made that care worse and it may be at once admitted that conditions under insurance in most countries are superior to those existing before its introduction. This, however, is no test of the effects of such systems.

There has been almost continuous improvement in medical service in the United States since 1883 when the German system of insurance was introduced. There has been great progress here since 1912 when the English insurance law was enacted. Indeed, all of the available facts seem to indicate that the improvement in service given in the United States to the classes corresponding to those which are insured in countries having insurance systems has been far greater here, than in Europe.

The object of medical service is to relieve and cure disease where possible and to reduce the sickness and death rates. The demand for medical services, as measured by the statistics of the insurance administrations, has more than doubled since the introduction of insurance in England and Germany. If it is claimed that these statistics are rendered unreliable because they measure the recorded illness for which cash relief was granted, and that therefore illness was sometimes feigned in order to secure cash, this does not reduce the force of the indictment against insurance.

The death rate is falling in nearly all countries. The mission of the medical profession is to reduce or abolish disease wherever possible. Medical discoveries in one country are at once freely made available throughout the world. As a result, such diseases as typhoid fever, smallpox, yellow fever, various forms of "plague" and a number of other diseases have been reduced in extent and severity and some have been almost completely eradicated. Many of these victories have been gained since the introduction of insurance but none can be credited to the workings of insurance systems.

The mortality rate has decreased and the average life expectancy increased almost everywhere, but these gains have been slower in coun-

tries where a large section of the population is covered by sickness insurance.

The question will be asked as to what alternative is offered to the proposal of the affirmative and the proposal for compulsory health insurance. The answer is clear and definite. It is to continue, and if possible hasten, the lines of progress that have already placed the United States far ahead of nations that have tried these sickness insurance or other medical service experiments. All progress must start from where we are now. It must utilize all that is best in present conditions, eliminate that which is harmful and thoroughly test all proposed steps in any direction. Traveling by airplane 100 miles in the wrong direction does not bring us as much progress toward the desired destination as walking one mile along the right road.

## SICKNESS INSURANCE AND SICKNESS COSTS

(Excerpts from an article by Morris Fishbein in Hygeia, volume 12, pages 1070-1076, December, 1934.)

In the days when a doctor traveled in a buggy or on horseback and carried his drugs with him in a satchel or in his saddle-bags, the expense of medical practice was not great. In those days the doctor made most of his diagnoses from what the patient told him and from such simple examinations as he could make with his five senses. Nowadays he uses all sorts of intricate apparatus for determining definitely the condition and ability to function of various organs in the human body. Today by use of the X-ray and various dye substances that are injected into the body the doctor can actually see the outlines of almost every internal organ. No longer is it necessary for him to guess at the changes that have taken place in the blood. They can be measured by chemical, physical and microscopic tests in the laboratory. Around 1890, medicine was practiced only by the doctors with the aid of a few nurses. Today in addition to the 155,000 doctors in the United States, there are about 1,250,000 other people who spend their full time in taking care of the sick. These include nurses, practical nurses, dieticians, X-ray technicians, laboratory technicians, anesthetists, ambulance drivers, orderlies, radio technicians, hospital clerks, hospital librarians, social workers and innumerable other special employes. Whereas we formerly had less than 1,000 hospitals in the United States, we now have about 7,000 hospitals. Overhead in medical practice has become tremendous, and the medical bill has proportionately increased.

In an earlier day when a child was sick, the family usually took care of him at home. Rarely was there any need for a hospital bill. Nowadays practically all surgery and a good deal of medical care in serious diseases are carried out in the hospital. A part of the reason for this is the changing character of our civilization. With people living in kitchenette apartments and with mothers working in industry, perhaps there is neither room nor the conveniences for the care of the sick at home. Frequently, there may be no one at home to carry out the doctor's orders and to help in nursing the patient.

Modern medicine, therefore, costs more than medicine used to cost. But it is worth a great deal more! Through the advancement of modern scientific medicine the expectancy of life at birth has moved up from 33 years to almost 60 years. Vast numbers of people live longer than people used to. As a result, one of the big problems of the day is the care of the aged. Moreover, there has been increased human happiness through increased health. Without health there can be no real happiness. Infant mortality rates have been cut down so that today only from 50 to 75 babies out of 1,000 who are born die in the first year of life instead of from 250 to 350 out of 1,000, which was the rate around 1890.

The investigators who have been studying the problems of medical care have found that the biggest difficulty today is the question of distribution. Not everyone can afford large hospital bills or large medical bills. People have not learned to save against the cost of medical bills as they have saved against the cost of death. Life insurance is one way in which people save against the cost of death. Sickness insurance is a way of saving against the cost of sickness. When enough people save against the cost of death and in order to leave a little something for their families, life insurance rates are cheap. It has been the hope of a good many economists and social workers that some means could be found to cause people, whether sick or well, to put a certain sum of money away each week with the hope that they might have money available for paying the costs of severe sickness when it came upon them. By its elimination of a good deal of serious illness, medicine has wiped out the fear of disease and it is, therefore, exceedingly difficult to make people save against disease. Death they know is certain, but on disease many of them are willing to gamble.

There are a good many foreign countries with systems of sickness insurance controlled by the state. The English system is an example. It was developed by Lloyd George in 1911. Recently he said that nobody wanted the law when it was first proposed. However, the Liberal party with which he was associated offered the system to the people as a panacea against much of the social unrest prevalent in England at that time. In the same way it is generally recognized that the German system of sickness insurance was offered to Germans by Bismarck in 1883 to allay the unrest then prevalent in that country.

In brief, these systems provide that workers who receive less than a certain sum of money annually shall have set aside from their wages a certain amount. The employer contributes a certain amount, and the state contributes a certain amount. This money is then made available for the care of most ordinary illnesses.

It has been shown that 90 per cent of the conditions for which most patients consult doctors can be diagnosed and treated by a good general practitioner with only the amount of equipment he can carry in a handbag. Most people do not worry much about paying for that kind of sickness. In this country the bills that disturb them are those for major illnesses such as pneumonia and gastric ulcer and for operations as in cases of appendicitis and gall-bladder disease. Nevertheless in Great

Britain the sickness insurance system does not provide for these major illnesses but only for general medical service. When a man under the British system has to go into a hospital, has to have a specialist and is unable to pay, he goes into a charity hospital and is treated there by doctors who work without payment as they always have in the past. It has been a tradition of medicine that it always gives its service to the poor without question. Every year the doctors of this country give many millions of dollars' worth of service for the poor, getting in return for it only the experience and such prestige as comes from having one's name on the staff of a great charity hospital.

The reader who has been following this discussion probably realizes by this time that there is no perfect system of sickness insurance that has been worked out as yet in any nation. Even those who are most ardent in their desire to have some kind of a system in this country freely admit that none of the systems in use abroad would do for the American people. One of the reasons is the fact that Americans always like to choose their own doctors. A good many of the systems of sickness insurance that have been provided in foreign countries do not permit the man to choose the doctor whom he wants. Furthermore, after the sickness society or the sickness insurance system selects a doctor for him, the worker finds it rather hard to change to another doctor even when he and the first doctor fall out. After all, the relationship between doctor and patient is one of the most intimate of human relationships. In some ways it is even more intimate than the relationship a man has with his family. One of the reasons why American doctors have been opposing any form of state control over medicine is the likelihood that any system of state control will interfere with this personal relationship between the doctor and the patient.

American doctors are proud of the kind of service that they have been giving to the American people. They can point to the fact that our sickness rates and death rates are about as low as, if not lower than, those of most of the large countries of the world. They can point to the fact that an investigation recently made by the bureau of economics of the American Medical Association revealed the fact that there are few, if any, people in the United States really suffering for a lack of medical care. The mayors of a hundred cities of various sizes testified to the fact that there was no neglect of the poor because of their inability to pay.

Another reason why American doctors are somewhat opposed to these state or similar systems of sickness insurance is the fact that the quality of medical care rendered under such systems in foreign countries is far below the average quality of care usually given in this country. In most of these systems a doctor gets a list of about 1,000 to 1,500 persons whom he is supposed to look after when they are sick. He gets so much a person each year for the service. In addition, in many countries, he carries on his private practice on the side. Now doctors are only human! By the very nature of the circumstances there is a tendency to give less attention to those who come under the insurance system than

to those who are directly responsible to the doctor for payment. When the doctor is directly responsible to the patient and the patient directly responsible to the doctor, the relationship is such that it is likely to yield the best type of service. It has been found, on the other hand, that the patient who comes in as an insurance patient is likely only to be asked a few questions and handed a bottle of liquid medicine or a package of pills and then told to come back a little later. However, even the kind of medicine or pills that he gets is regulated by the laws controlling such systems. The state does not care to spend any more on him than it has to and it therefore limits the price of the medicine that can be prescribed. In a recent report on the insurance act in Scotland it was found that one patient had received about 800 pounds of boric acid ointment during a period of eight years, for a chronic skin disease that he had. There are also some pretty strong stories about sickness insurance doctors who come into their offices and ask all the patients with a cough to stand up. They get cough medicine. That kind of diagnosis, which may overlook a beginning of tuberculosis or pneumonia, is not a safe method of diagnosis for any self-respecting citizen. When an American doctor practices such slipshod medicine, he is not likely to get much practice.

The Germans say that insurance service is always second-class. The reason is, of course, that the leading doctors will not do this kind of practice. It is a system which aims to take in the lower third of the medical profession. For patients who are on sickness insurance lists will go to an outside doctor and pay his fee when they think that anything serious is wrong with them.

The people who have been trying to promote a sickness insurance system in this country are telling the doctors that they are going to make more money for them under the new system. Possibly they will. In England the lower third of the profession found its income increased somewhat when the sickness insurance went into effect. A little later, however, when the financial emergency hit England, the authorities began to cut down the amount of money per annum, and the lower third of the doctors whose incomes had been improved suffered. At the same time, of course, the income of the private doctors was cut down because so many more people had been put on the sickness insurance lists. In England where only the actual worker and not his dependents are covered by insurance, the average income of the doctors who carry on insurance work is a little over $2,000 a year, and the doctor has to pay his expenses out of that. Such doctors are still allowed to have such private practice as they can get, but many of them do not get much. The panel doctor, as he is called, is paid a little over $2 yearly for each person and has to have 1,000 people on his panel to get $2,000. In the United States we already have so many doctors that the number of patients for each doctor is about 800.

I mentioned earlier in this article that this question of sickness insurance is being agitated more by social workers than by any one else. The vast majority of doctors do not want to practice under that kind

of system. As far as I can find out, there has been no particular desire for the system voiced by organized labor. The industries and the manufacturers are being so much troubled with taxation and with the problems of unemployment insurance and old age pensions that they do not seem particularly interested in putting over any systems of sickness insurance. The American Legion, which represents a tremendous number of men in this country, has recently voiced its opposition to all socialistic, communistic, and similar experiments.

All over this country right now experiments are going on in counties, in cities, in relationship to hospitals and in relationship to industry, whereby people who are organized in small groups are working out systems for saving against the costs of hospital care and against the costs of sickness. The medical profession has never objected to such experiments provided they are carried out in such a manner as to protect both the patient and his doctor against exploitation and to maintain the quality of medical service. Out of these experiments several systems and plans will probably come eventually which can be extended to other communities and other industries of similar character.

The doctors have recognized the necessity of giving to all the sick the right kind of medical care. They have always done it in the past, and there is no reason to believe that they will fail to do their duty and to maintain their ideals in the future.

## THE CASE AGAINST STATE MEDICINE

(Article by Wingate M. Johnson in the Forum and Century, volume 90, pages 304-307, November, 1933.)

The majority report of the committee on the costs of medical care, recently submitted after five years of preparation, was, in military language, a "dud." It is true that a few lay publications and a very few medical journals displayed a mild enthusiasm, but for the most part they either condemned or, worse still, ignored.

There are a number of reasons for this lukewarm reception, although the report had been backed to the tune of a million dollars by eight "foundations," each financed by one or more "big business men." Their idea was to apply to the practice of medicine the methods of mass production which were once apparently elsewhere so successful; but by the time the committee had spent its money and issued its report, the big business man and his mass-production methods were alike so thoroughly discredited that no amount of ballyhoo could pump up any enthusiasm for their application to the ancient and honorable profession of medicine.

One recommendation of the majority of the committee was that medicine be organized in smaller towns around hospitals as nuclei, supervised by super-organizations in the larger cities; but the chain store idea did not appeal to a public holding numerous shares of Montgomery Ward, Sears Roebuck, and A. and P. stocks that were daily declining in value. And the recommendation "that the costs of medical care be placed on

a group-payment basis, through the use of insurance, through the use of taxation, or through the use of both of these methods" did not appeal to a public already staggering under a load of taxes too heavy to bear. And when it later developed that some of the same "philanthropists" so interested in shifting the responsibility for the health of their employes to a paternal government, rather than pay them decent wages, had themselves adroitly side-stepped their own taxes for a number of years, John Smith was still harder to interest in adding to the burden of his own back.

Perhaps the chief result of the committee's report has been to focus attention more sharply than ever upon state medicine, which was virtually recommended by it. One member refused to sign the report because it did not specifically recommend state medicine to begin with; and in a recent Forum he presented a very clear and forceful argument for the faith that is in him. Theoretically, much may be said for it. Everybody would have the privilege of consulting, without thought of the cost, the physician of his choice. On the other hand, every doctor would be assured of a fixed income. All the financial burden would be distributed in taxes and paid according to the ability of the taxpayers. (Recent investigations might amend this last sentence to read "according to their skill in evading taxes.")

## II

Now let us consider the arguments against state medicine. First, while its advocates draw a picture of the medical plight of the people that would draw iron tears down Pluto's cheek, the people themselves are not in such a bad way. Statistics are boring, but when the death rate in our own state has fallen from 12 per thousand in 1923 to 9.6 in 1932 and when the average life has been lengthened about 15 years within this century, it is hard to see how the people are so badly neglected. It is quite true that this life-lengthening is in the early years rather than the latter; but it is also true that the strenuous pace which our big business men set for themselves and their employes has much to do with the degenerative diseases that beset the elderly among us. If such men would learn to content themselves with less profits and would pay their workers living wages, both parties to the contract would benefit physically as well as spiritually. Pressing the point still further home, the committee's report laid great stress upon the fact that the income of the average family was too low to enable it to have adequate medical care; but instead of recommending a concerted effort to have wage scales raised, advised that the burden be shifted to the backs of the taxpayers.

Furthermore, I question the accuracy of some of the premises from which the committee drew its conclusions. One study included a survey made by the Metropolitan Life Insurance Company with the obvious intention of making the cost of medical care for the average family appear as large as possible. In their study the first six months of 1929 were used, and the family under survey reported to the visiting nurse

the amount of their medical expenses. The figures thus obtained were multiplied by two and used as an annual average. As a matter of fact, however, the Metropolitan's own statistics show that this period included the highest influenza incidence for the whole five years. The resulting figures were obtained by an enterprising reporter for our daily paper, who applied them to our own county, stating under glaring headlines that the average income of the Forsyth county physician was considerably more than $12,000; whereas it is doubtful whether a single physician in the county could boast that much. My secretary estimated that if the figures of the committee held good, basing my income on the number of families on the active list and allowing a goodly share for the specialists, I was getting only a third of the amount due me.

But let us consider the individual case of the middle class man or woman who is confronted with an emergency operation or illness and who has not the funds on hand with which to pay for it. No article advocating state medicine is complete without this case report, in which the doctor is usually pictured as a sort of Shylock demanding his pound of financial flesh. Well, I know that if John Smith will tell his doctor frankly his circumstances and ask to be allowed to pay his bill in small installments, the doctor will gladly wait upon him. And I know, furthermore, that if John Smith has been depending for years upon one family doctor, who knows he pays according to his ability, that this doctor will not let him suffer for want of medical attention because of financial straits. Usually, too, the family doctor is apt to have influence enough with a surgeon or specialist to negotiate, if needed, an operation which can be paid for as convenient.

My firm belief is that the average doctor will be far more lenient in dealing with John Smith than will the tax collector.

State medicine would add so enormously to our tax burden that the groanings heard during the past few years would fade into insignificance beside the roars that would result from this added load. And does anyone think for a moment that with such a tremendous new source of revenue our politicians would keep their hands in their pockets? Not unless human nature changed overnight—and a rereading of the section on Democracy in Plato's Republic will convince the most skeptical that the political leopard has not changed his spots, in twenty-four centuries at least.

Our educational system is frequently cited as a parallel case. Granting for the sake of argument that it is—how many Forum readers will concede its success? Certainly the article by Mr. James Metzenbaum in the June Forum on the school situation in Cleveland is not calculated to inspire confidence in the integrity of those who disburse the funds paid by taxpayers for education; and nobody believes that Cleveland is an isolated example. Those who want the taxpayers to assume the medical burden of the country should take warning from the rapidly mounting costs of our secondary-school system. In 1880 the cost to the taxpayers was $5 per capita; in 1914, $21.34; now the annual cost is close to $100. Whether or not this is ever paid remains to be seen;

but that we are failing to get our money's worth is certainly not to be debated. No less an authority than Ellery Sedgwick declares that "American education is a thing of trappings and appurtenances. Our schools are palaces and our colleges places to wonder at. But the teacher is not a leader, and the pre-eminence of the learned man is not unquestioned."

Certainly the physician who values his self-respect would hate to undergo the humiliation the average teacher must feel in cringing before her principal, or the principal before the superintendent, or the superintendent before the august body of politicians known as the school board. Yet if the physician's living depended upon pleasing a political superior, what else could be expected?

III

State medicine has already been tried in Europe. As is the case in most debatable questions, one may get opinions pro or con, according to the personal bias of the investigator or of the informer. This may account for the fact that most of the reports that have come to my ears and eyes have been unfavorable; but the fact that most of my information has been gleaned from medical journals which, in turn, have had their reports directly from doctors or from distinguished citizens, rather than from politicians and specialists in other people's business, should give it weight. A typical expression from a private physician is from Dr. Edwin Liek, of Danzig: "social insurance is today organized to fill the feed trough of bureaucratic drones." Dr. Edward Ochsner, after a careful first-hand study of the situation, says, "Germany has had social insurance the longest and has for a considerable time been on the verge of bankruptcy. While other facts are operative, we believe that the billion dollars which social insurance costs the nation every year is one of the chief reasons."

Evidently the committee recognizes that the European experiments in the socialization of medicine have not been satisfactory, for it proposes to improve the situation by substituting group practice for individual doctors: "many of the difficulties experienced . . . under European systems will be avoided, the committee believes, if service is obtained from well-organized groups." Yet a survey just completed by the American Medical Association indicates that group practice is meeting with opposition, both within and without its own membership, and that its popularity is declining.

It is, of course, wandering from our text to discuss group medicine, except for the committee's statement that if it be substituted as the medical unit, rather than the individual practitioner, it would do away with objections to the European systems and make medicine work in America. As I have said in a previous article, those who would substitute group practice for the individual doctor base their contention upon two great fallacies: first, that the average patient needs an exhaustive examination to find out what is the matter with him; secondly, that modern medical science can solve all disease problems. The first

fallacy is exploded by the generally admitted fact that a competent general practitioner is capable of caring for from eighty to ninety per cent of the patients who consult doctors. The second fallacy is demonstrated almost daily in all our great clinics. Any doctor in the country can supply case histories in abundance.

The group practice trend of the committee is understood when it is known that Mr. Edward A. Filene of Boston was largely responsible for its organization. Mr. Filene's ideas had already been set forth in a previous magazine article by Mr. Evans Clark, the director of his Twentieth Century fund. This article suggested that "possibly the most fruitful arrangement would be a group composed of two-thirds of doctors and one-third of experienced executives, with perhaps an economist or two thrown in." As a plain, blunt medical man, I cannot help wondering who would get the most fruit from such an arrangement—the doctors or the "experienced executives." Evidently doctors must be considered on a low plane mentally if it takes one business man to manage the affairs of two doctors—not to mention "an economist or two" thrown in! And yet we are supposed to believe that such an arrangement would enable medical service to be dispensed more cheaply! Of course the number of "experienced executives" and "economists" available is much larger now than a few years ago—but what recommendations could they furnish?

An inescapable conclusion is that the majority of those who advocate state medicine, like the majority of the committee, do not regard the members of the medical profession as having sense enough to manage their own affairs. I am reminded of a doctor friend who, just out from an attack of influenza, was twitted by a banker for not knowing how to keep himself well. His patience already worn threadbare by frequent repetitions of this hoary joke, he replied: "if we doctors had made as big a mess of our job as you bankers have, I wouldn't have the nerve to criticize anyone else." Considering the mess the big business men, some of whom are sponsoring the work of the committee, have allowed their own affairs to get into, it does seem in order for them to sweep up their own premises before giving their advice unasked to the profession that has suffered most grievously from the poor judgment of these same "experienced executives." Why should they be allowed to apply to the practice of medicine in America the same principles that have well-nigh wrecked the medical structure of other countries? As a brilliant medical editor said more than three years ago: "ninety-five per cent of our population are better satisfied with their doctors than they are in their relations with their landlords, their grocers, their clothiers, their preachers, or the teachers of their children."

## IV

After all, the question of state medicine is bound up with the socialization of the state generally. With so many other pressing public needs, why should the medical profession be singled out for attack? Does not the public need fuel and clothing and food? And are not

the costs of these subject to great fluctuations, just as is the cost of its medical care? Why not, then, let us join Russia in her "noble experiment" of communism, and be done with it? There a doctor gets twelve dollars a month for working six hours a day: some of them double and work twelve hours a day for $24 a month.

Already our people have been spoon-fed by the hand of the government until they have lost much of their independence. A long step toward the complete loss of self-respect and manhood would be taken if they were still further pauperized by having free medical service forced upon them.

It is almost impossible to overestimate the effect state medicine would have upon the doctor himself. It is recognized and admitted that some of the most brilliant discoveries and greatest medical triumphs have been achieved by medical men working for salaries in government laboratories or such semi-public institutions as the Rockefeller Institute. It is true, however, that the research worker is altogether different from the practitioner. The researcher does better work for having his living provided for him, leaving him a free mind to apply to his laboratory. The practitioner, on the other hand, is an individualist by nature and by training. He learns to rely on himself, and is cramped if forced to take orders from higher authority. It is true that the stress of competition in private practice may develop heart burning jealousy among its members; but it has also brought forth their best efforts. And a much higher incentive than that of competition is the trust imposed in him by his families. To merit their confidence, the right sort of doctor will make almost any sacrifice.

Under state medicine, inevitably the old relation between doctor and patient would be destroyed. There could not be the same interest taken in his patients by a doctor working for the state as by one in private practice. In no other profession does the personal equation count for more than in medicine; and nothing would destroy this more quickly than state medicine, particularly if practiced by groups.

## THE SOCIALIZATION OF MEDICINE

(Excerpts from an address by Paul P. McCain at the meeting of the N. C. Medical Society at Pinehurst, May 7, 1935, as carried in Southern Medicine and Surgery, volume 97, pages 311-318, June, 1935.)

Regardless of the present apparently favorable attitude of the public in North Carolina toward our profession, every member of our society must be awake to the tremendous dangers which threaten both the public and our profession the country over from the socialization of medicine.

For a number of years there has been some agitation for socialized medicine. The depression gave further impetus to the movement. It has been largely sponsored by social agencies, philanthropic foundations, so-called efficiency experts, politicians; and even by a few physicians, most of whom are in administrative positions and who are not and who probably never have been in the actual practice of medicine. The fact

that many of the advocates of socialized medicine are well-intentioned and honest in their efforts makes the danger of what they may be able to accomplish all the more potential. The theory that such plans will provide adequate nursing, dental, hospital and medical care to all, and that physicians, dentists and nurses will have surer and better incomes makes a strong appeal to those who are not thoroughly familiar with the problems involved.

At present there is no real demand for socialized medicine by the public, but the fact that its advocates have enlisted the sympathy of our great President to such an extent that he has taken the initial steps toward securing legislation for the socialization of medicine should make the profession realize it must give most serious study to the whole problem.

Sickness insurance is the plan which the advocates of socialized medicine advance as the solution of all our ills. Sickness insurance, either on the voluntary or compulsory plan, will not solve our problems. If a sufficiently large proportion of the low-income group would join the voluntary plan, and if their income remained steady, this would go far towards solving many of the problems of adequate medical care, but no voluntary plan has ever been devised which was sufficiently attractive to secure as members any large proportion of those unable to pay for their medical service. On the voluntary plan the young and healthy will not participate, and any plan carrying a large proportion of the sickly and aged is doomed to failure.

At its last annual meeting in June the house of delegates of the American Medical Association gave special consideration to this problem. It went on record as opposing compulsory sickness insurance in all forms, and it laid down the following ten fundamental principles upon which any scheme for the furnishing of medical care by the members of the American Medical Association and of all component societies must be based:

First: All features of medical service in any method of medical practice should be under control of the medical profession. No other body or individual is legally or educationally equipped to exercise this control.

Second: No third party must be permitted to come between the patient and his physician in any medical relation. All responsibility for the character of medical service must be borne by the profession.

Third: Patients must have absolute freedom to choose a legally qualified doctor of medicine who will serve them from among all those qualified to practice and who are willing to give service.

Fourth: The method of giving the service must retain a permanent, confidential relation between the patient and a "family physician." This relation must be the fundamental and dominating feature of any system.

Fifth: All medical phases of all institutions involved in the medical service should be under professional control, it being understood that hospital service and medical service should be considered separately. These institutions are but expansions of the equipment of the physician. He is the only one whom the laws of all nations recognize as competent

to use them in the delivery of service. The medical profession alone can determine the adequacy and character of such institutions. Their value depends on their operation according to medical standards.

Sixth: However the cost of medical service may be distributed, the immediate cost should be borne by the patient, if able to pay, at the time the service is rendered.

Seventh: Medical service must have no connection with any cash benefits.

Eighth: Any form of medical service should include within its scope all qualified physicians of the locality covered by its operation who wish to give service under the conditions established.

Ninth: Systems for the relief of low income classes should be limited strictly to those below the "comfort level" standard of incomes.

Tenth: There should be no restrictions by non-medical groups on treatment or prescribing unless formulated and enforced by the organized medical profession.

These ten principles were also unanimously endorsed by the executive committee of the Medical Society of North Carolina.

The advocates of compulsory sickness insurance have been most active through every form of propaganda in trying to create a demand on the part of the public for the passage of laws embodying compulsory sickness insurance. The danger of their being successful, especially with the apparent support of President Roosevelt, was such that, as you already know, the board of trustees of the American Medical Association called a special session of the house of delegates for the 15th and 16th of February to give special consideration to this subject. You are also familiar with the action of the special called meeting of the house of delegates of the American Medical Association in reaffirming their previous action and in heartily condemning "all propaganda, legislation and political manipulation leading to all plans of medical practice which result in regimentation of the medical profession and the lay control of medical practice."

One of the principal arguments of the advocates of compulsory health insurance in this country is that it has been in operation for years in most of the countries of Europe, and their claim is that it has been found to be satisfactory. The facts, however, in no way justify their claim. In none of the countries in which compulsory health insurance is in force is the mortality or the morbidity rate so low, and in none are preventive measures so widely used as in the United States. Under insurance the "will to be well is strangled," the number of neurotics and malingerers is tremendously increased, as is the demand for needless drugs. Furthermore, compulsory insurance plans do nothing at all for furnishing medical care to the indigent sick.

Insurance plans also result in a very inferior grade of medical service. Physicians have to see patients on such a wholesale scale that there is not time for accurate diagnosis and proper treatment. The patient frequently has no choice of physician and the essential confidential relationship between patient and physician is lacking.

The results of health insurance are also most unsatisfactory to the medical profession. Physicians are under the domination of lay groups and politicians. Physicians are employed by lay directors either on a salary or on the basis of the low bidder either on a fee or per capita basis. Honest, conscientious physicians have to bid against those who are unscrupulous and who are interested only in getting the practice. The desire of physicians to do thorough and scientific work is crushed. They are so weighted down with routine and red tape that they have little time for study. Their time is taken up largely with endless reports to their lay supervisors. When health insurance is coupled with cash benefits for time lost during the period of sickness the evils for the physician are multiplied. The patients have a much greater tendency to malingering and the doctor often has to play the distasteful role of physician to the patient and inspector for the insurance company.

Furthermore health insurance is a most expensive method of rendering medical service. The administrative cost of compulsory health insurance is tremendous. The number of laymen to whom the physicians are responsible outnumber the physicians.

There is no group more anxious for every individual, be he rich or poor, to have adequate medical care than the organized medical profession. As is so well stated in the report of the called meeting of the house of delegates of the American Medical Association, "the primary considerations of the physicians constituting the American Medical Association are the welfare of the people, the preservation of their health and their care in sickness, the advancement of medical science, the improvement of medical care and the provision of adequate medical service to all the people." It is to organized medicine that the public is indebted for the present quality of medical service, for the high ideals of the profession, and for the gift without commercialism of all the scientific discoveries and inventions of its individual members. What group has labored so tirelessly and earnestly to eradicate the very source of its livelihood? No profession can boast a record of more unselfish service. Without regard to personal comfort or safety the medical profession has ever responded to the call of the sick day or night, in sunshine or storm, in pestilences, in epidemics or in war. What other profession can boast of so many members who willingly gave their lives that civilization might march forward?

Is it right or proper that the system of medical practice developed by such a profession through centuries of effort should be consigned to the scrap heap, and that a new system conceived by theorists and elsewhere found inimical alike to the best interests of the profession and the public should be substituted with the moral and financial backing of the government? Is it right to ignore organized medicine in the development and discussion of plans for improving or supplementing the present plan of rendering medical service?

No group is more conscious of certain needed improvements than the organized medical profession. A profession which is so noted for scientific experimentation is also ready to experiment in certain fields

of socialized medicine, but we must not countenance experiments which are likely to destroy the very foundation upon which all medical progress has been builded. Already in many sections of the United States various experiments in the furnishing of medical care are being conducted under local and state medical societies with the approval of the American Medical Association. We are told that approximately 150 such experiments are in progress at the present time. In a country like ours no plan is applicable to all sections nor to all low-income groups.

## DO WE NEED COMPULSORY HEALTH INSURANCE? NO

(Excerpts from an article by R. G. Leland and A. M. Simons in the Annals of the American Academy of Political and Social Science, volume 170, pages 121-127, November, 1933)

Those who urge health insurance are always indefinite as to its objective. This confusion, carried over into the operation of the scheme, is further confounded to the ultimate failure of nearly all the objectives.

One of the most commonly announced objectives of the politicians is to prevent revolution. Recent events have shown the failure of this objective. Another objective of the politicians, not usually announced, is the construction of a political machine and the creation of a system by which votes can be purchased by insurance benefits. This is one objective that has been fully realized, although in many instances the machine has been taken from those who constructed it and used to crush its originators.

A third objective, which is also seldom announced in the beginning but which soon becomes a major purpose, is the subjection of the medical profession to lay control. Sir Henry Maine has told us that one of the principal characteristics of the evolution of industrialism from feudalism was the substitution of "contract" for "status" in human relations. The professions have always resisted this tendency and maintained that such a change destroys the most valuable characteristics of professional services. The administrators of health insurance in European systems make no secret of their determination to force medicine into industrial patterns. They declare that physicians must pass from the stage of "small entrepreneurs" based on a professional status into the contract relation of employes in great medical organizations. They demand that admission to insurance practice and choice of physician be controlled by lay administrators. This program is stated in almost these very words in the report on "Methods of Controlling the Medical Service in Sickness Insurance" of the Fourth General Assembly of National Unions of Mutual Societies and Sickness Insurance Societies held at Dresden, October 19-22, 1930.

Although the advocates of health insurance in this country are less definite in announcing this objective, anyone who examines the publications of the committee on the costs of medical care and the statements of those most eager to introduce insurance will have no difficulty in detecting the same attitude. They make the same erroneous claim for great

medical efficiency through groups organized on industrial patterns, that are made by the lay administrators of health insurance in Europe. Incidentally, European studies have already revealed that such groups by no means show even the financial efficiency claimed for them. A recent study in this country also leads to the conclusion that group practice does not reduce the cost of medical care nor necessarily improve the service.

The fourth objective is supposed to be improvement in health and reduction in the morbidity of the insured. Here the failure is most complete. A study of the morbidity rates under sickness insurance would give the impression that insurance itself is some sort of deadly infection. Insurance always brings a steady, rapid increase in the amount of recorded illness. To be sure, the illness which is measured is of much the same character as that studied by the committee on the costs of medical care, and is probably no accurate measure of pathologic conditions.

Fifty years of health insurance in Germany have seen the number of days lost from labor through sickness in the insured population increase nearly threefold. Twenty years in England doubled the original rate. This is not due to increasing age, because the rise is equally great among those in the prime of life. It is not wholly due to the anxiety to obtain out-of-work benefits, although this is a major cause, since there has been an almost equal increase in illness among dependents who receive medical benefits although not eligible for cash benefits.

That this is peculiarly an insurance phenomenon is shown by the fact that the insured in Germany show an illness rate ten times that of the uninsured. This tremendous rise in the morbidity rate has come during a period in which, owing to the triumphs of modern medicine and their application, the death rate in every country has steadily and rapidly decreased, and in which the morbidity rate from a number of once highly prevalent diseases like typhoid, smallpox, and diptheria has been greatly reduced.

This increased morbidity is directly caused by insurance. After a few years the insured, who have been making continuous sacrifices from their scanty wages, become filled with a desire to "get something back." They get cash benefits if they can, but, failing this, they are determined to receive medical attention and drugs. German physicians estimate that from 50 to 75 per cent of all the illnesses treated by insurance physicians do not need medical attention. They are to some extent the "minor respiratory diseases" recorded by the committee on the costs of medical care, and other equally minor diseases—the "bagatelle cases" that are so much discussed by writers on the German system. The same condition exists in all other systems. English physicians complain that insurance is creating a race of "bottle addicts," because if the physician does not give them a prescription he loses his patients, who feel that they have not "got their rights" out of the insurance to which they have contributed.

There are even worse phases of this situation than the creation of "bottle addicts." A physician who must spend 60 per cent of his time with those who do not need his services cannot give adequate care to

those with serious complaints. It is not alone that his time is so wasted in useless consultations as to give no time for proper examination and diagnosis when needed, but also the atmosphere which is created is one of suspicion and antagonism between patient and physician. The patient believes that he is denied attention and drugs because the lay administration insists on "economy" in the expenditure of his contributions.

Where the physician must also certify to inability to work (which is the situation in all existing systems), this antagonism is so multiplied as to cause universal complaint from the medical profession. The demand that the physician act as the policeman for the insurance society treasury so destroys the confidence upon which proper diagnosis and treatment depend as to make it almost impossible to give good medical service. Instead of reducing the cost of medical care, insurance so adulterates that care with suspicion, haste, and conflicts as largely to destroy its value.

It has been mentioned that insurance itself is a cause of disease. Dr. Viktor von Weizäcker, head of the oldest and one of the most famous psychiatric clinics in the world, at the University of Heidelberg, declares that the neuroses caused by the conflicts over "rights" and "wishes" built up by insurance complicate most of the illnesses treated and create a multitude of new illnesses.

The medical profession in health insurance countries does not criticize insurance from any selfish economic reason, although the developments of almost half a century of the system in Austria have destroyed private practice and reduced the payments for a visit to between 15 and 20 cents. Contrary to repeated statements made by the advocates of insurance in this country, the medical profession did not generally oppose the beginnings of health insurance. On the contrary, the history of nearly every system except the most recent ones tells how the physicians at first freely gave their services as a contribution to what they considered a new form of philanthropy. But they have not been encouraged by its later developments, and they especially protest against its effects upon the patients. They see in the attempt to thrust a profession into an industrial pattern a destruction of the greatest values of that profession and of that absolutely essential ingredient of good medical service, mutual confidence between patient and practitioner.

The medical profession believes that laymen, who are prohibited by the laws of every nation from practicing medicine, should not be permitted to supervise that practice. It is the mission of the profession to fight disease and maintain the health of the people. The mortality records of every modern nation testify to the way it has fulfilled that mission. The measures which it has proposed and supported have doubled the average age and abolished some of the worst scourges of mankind during the last century.

That task is by no means completed, and the resources required for the extension of the legitimate functions of health departments, for immunization, for research, for improved housing and sanitation, and other activities that, unlike health insurance, have proved their ability

to reduce mortality and morbidity rates, are still wholly inadequate for the work needed. The experience in countries with health insurance has shown that the tremendous expense and the elaborate machinery required for the operation of such systems tend to reduce the money and the energy spent in other much more desirable and more productive directions.

Centuries of tradition and the sharp experience with health insurance during the past fifty years have convinced the profession that there are certain conditions of medical practice which can be violated only at the cost of destroying the most valuable features of the service given:

(1) There must be control by the organized profession of all features of that service. No other body is legally or educationally equipped to establish and maintain the standards of that service.

(2) No third party must be permitted to intervene between the patient and the physician in any of the relations connected with medical service. There is no other basis for that mutual confidence which is essential to accurate diagnosis and proper treatment.

(3) The patient must be allowed to choose with absolute freedom the physician from whom he desires service, among all those legally qualified to practice. That choice or the character of the service given must not be influenced by the financial interests of any third party or organization.

(4) All medical institutions giving medical service must be under the control of the medical profession. Such institutions are but the enlarged instruments of medical practice and should not be directed or managed by those not authorized to conduct such practice.

No system of national health insurance has ever been developed that did not violate one or more of these fundamental conditions of good medical service. Until a system is developed and tested that meets these conditions and until the resources available for methods of health care that have been proved effective are large enough to meet the really urgent demands of such care, it would seem that we do not need health insurance.

The type of medical practice which best serves the public needs is the type which should be followed. Here and there adjustments may be necessary to correct a few obvious inconsistencies in certain phases of present medical practice, but thus far no convincing arguments have been advanced to warrant revolution in the methods of administering medical care which have stood the tests of centuries. The public deserves good medical care; the medical profession is best qualified to judge of the adequacy and the competency of that service; it has no desire to obstruct reasonable and honest efforts to provide good medical care. If there are groups of the population unable to meet medical costs, some of the reasons for the lack of purchasing ability are sure to be found outside the realm of the present costs and methods of administering medical service.

## SOCIALIZED MEDICINE

(Excerpts from an article by Morris Fishbein in the Nation, volume 126, pages 484-486, April 25, 1928.)

The modern science of medicine began with the discovery of bacteria by Pasteur about fifty years ago. Long before that time, however, Hippocrates had taught the art of observation and had called attention to the importance of the individual relationship of the physician to his patient. The most ancient of physicians recognized the fact that some persons could inspire the patient with a desire to recover and could apparently aid that peculiar power lying within the body known as the vis medicatrix naturae, the power within living tissue that urges it to repair.

As time has passed, facts and methods have accumulated. The old-time physician who graduated from a two years' course of lectures, the same lectures being repeated during the six months of each, practiced a sort of "hit-or-miss" method of healing. He took the history of the patient, looked at the tongue, thumped the chest, and listened to such murmurs as were easily apparent. On the basis of the general knowledge of the course of disease, he made a diagnosis. The practice of modern medicine is a much more complicated matter. It involves not only all of the things that have been mentioned, but also the use of much intricate apparatus, laboratory service, the X-ray; indeed, a study of all the secretions and excretions of the human body. As a result, the cost of medical care has increased greatly and is giving concern to sociologists and economists. For some time the statement has been made that only two groups of persons can afford to be ill, the wealthy and the very poor. The former are able to pay for what they get and the latter get a rather good type of service without charge.

The group that gives the greatest concern to students of the situation is the middle class. This group has been the victim of exploitation since the earliest times. It exists in one-room kitchenettes in the cities and must perforce go to the hospitals in times of sickness. In the country and in the villages it is far removed from the available hospitals and pays mileage charges in addition to medical fees for medical attention. Because of its transient character it has fallen out of touch with the old-time family physician. This group, therefore, usually provides the primary source of revenue for medical quacks of every sort. The member of the middle class is likely to attempt to save the cost of a visit to a physician by purchasing a patent medicine widely advertised in the press or by asking the corner druggist to prescribe. Middle-class workers are likely to join fraternal orders which maintain incompetent lodge doctors. Sometimes they work in large industrial plants or factories, where a certain sum is taken from their wages each week to pay for treatment in the factory hospital or for a visit from the factory doctor in time of sickness. As a result numerous leaders in the public-health field have urged the establishment of compulsory health insurance or other health schemes to provide funds for the middle class.

Some economists have insisted on a state system of medicine which

will provide health care in much the same manner as the state cares for education. Gerald Morgan, for instance, has insisted that there must be a radical change which will emancipate health in some way from the fetters of the existing acquisitive economic system and provide free periodic physical examination regardless of known ailments and some financial provision for the families of those needing help in time of illness.

Professor C-E. A. Winslow, when president of the American Public Health Association, said that the purely individualistic practice of medicine, as it has existed in the past, must be increasingly supplemented by a form or forms of organized medicine which will offer to the individual modern scientific medical care, including laboratory and specialized consultation service on an economic basis which will facilitate its application to the prevention of incipient disease—probably on some basis which involves payment of the physician through a common fund for the supervision of the health of an individual rather than for the treatment of a specific ailment.

The health-insurance scheme developed through the sickness societies of Germany has been the subject of debate ever since its establishment. The panel system in Great Britain continues to be the subject of discussion by both the medical profession and the public. That system grew out of what is known as contract practice, a system whereby families paid a regular fee each week or month to the physician for all of their care. The same system has been employed by trade unions and by lodges. Unfortunately contract practice resulted in scamped work, because the physician was invariably underpaid. Persons well able to pay took advantage of the opportunity to get service at minimum rates. In times of extraordinary illness the patient had to pay extra for special service or resort to charity. The medical profession was demoralized through political maneuvering for the most remunerative contracts. In 1911, under Mr. Lloyd George, the national insurance act, which gave rise to the panel system, was passed. Since that time it has been modified repeatedly. Any doctor can get on the list of those working under the act and there are in England, Scotland, and Wales some 35,000 so registered. Of these fewer than 15,000 are actually doing national insurance work. About 1,000 physicians, constituting an active minority, refuse to have anything to do with the whole scheme. The number of persons insured under the act is approximately 15,000,000, so that the average number of insured persons in the care of one doctor is about 1,000.

When accepting employment under the insurance scheme the doctor agrees to give such service "as can properly be undertaken by general practitioners of ordinary competence and skill." Thus those registered are not provided with the best that medical science can provide. The persons treated are those who do not earn above a certain minimum sum per week. The patient presumably has a free choice of physician, although this is governed by accessibility and the willingness of the doctor to take more patients on his panel. Some doctors have 400 on

their panels, others 3,000. There are material benefits for prospective mothers, and there are minimum fees for doctors; the latter have never been considered adequate; in many cases the physician must supply the drugs prescribed as a part of the fee.

The American medical profession has looked with increasing concern at attempts to establish similar state systems in this country. For instance, the committee on public policy of the Ohio State Medical Association, at its last annual meeting, presented a resolution which was adopted by that state organization, objecting to every possible encroachment of the state on private medical practice. They objected to the extention of free clinics, to the growth of health-insurance ideas, to the widespread propaganda for nationalization of property and socialization of personal service, to the increase in health charity for those able to pay, to personal health service without charge in educational institutions, and to every other tendency of governmental agencies and departments to interfere with the relationship between patients and their individual physicians.

The mechanization of medicine is an evil recognized by every physician as a menace to sound medical practice. Come what may, the intimate personal relationship of physician and patient is essential to complete relief of the patient's ills. Even the periodical physical examination is unsatisfactory when applied on an impersonal basis. True, it may detect the scientific evidence of incipient physical disease, but it does not get at the personality of the patient in the manner that formerly resulted from the relationship between the general practitioner and his patient. Even the best social-service technique may fail to find the human being that the old-time physician used to know in each of his patients. A single point in the life history of the ailing individual may explain the major part of his symptoms and his distress. Not infrequently that point is carefully concealed from everyone except the personal physician in whom the patient has the same confidence that members of some churches have in their priests.

The evils of socialized practice, indeed of any impersonal method of medical practice, are generally recognized. They involve inadequate compensation for physicians; the average salaries of doctors in state or commercial organizations rendering such service are between $3,000 to $4,000 a year, notwithstanding the fact that an adequate medical education may cost the doctor approximately $20,000 to $25,000. The standards of medical practice are lowered because the tendency of the contract doctor is to see as many patients as possible. Patients are moved along without adequate attention. In some parts of the country doctors engaged in contract practice attempt to see eighty or ninety patients each day. The physician falls into the deadly routine of contract work, initiative is lost, and advancement is dependent on the individual's ability to pull wires.

Only too often industrial medicine has become an instrument for fighting compensation claims. The salaried medical service of department stores and of factories is so impersonal that many employes

prefer, even though assessed for the provision of medical care, to seek out a personal physician in time of stress. Why should not a democracy attempt to insure the worker a salary or wage adequate to provide for medical treatment and ask the medical profession to organize itself for the provision of such treatment, rather than pauperize the middle class by degrading the medical profession?

More and more the advances in modern medicine reveal the essential differences between individuals that make routine methods of diagnosis and treatment impossible. More and more physicians are beginning to recognize the influence of mind in disease and in the treatment of disease, a factor invariably lost in mechanized practice. State medicine might provide a standardized diagnosis and treatment for a standardized citizen; but it means the death of individualism, of humanitarianism and of scientific practice. Until we become a nation of robots, with interlocking, replaceable, and standardized parts, there will be little need for completely standardized doctors.

## IS SOCIALIZED MEDICINE THE WAY OUT?

(Excerpts from an article by William H. Holmes in the Northwestern University Alumni News, volume 14, pages 8-9, 21-22, February, 1935.)

Medicine is the victim of many unjust accusations, but the gravest one I have seen is that which says that despite a surplus of doctors many people lack the barest fundamentals of doctoring.

That is the charge made by Howard Vincent O'Brien in the Chicago Daily News of December 8, 1934. A few days previously a Chicago physician was widely quoted as having stated that 50 per cent of the people were without adequate medical care. Neither critic offered evidence in support of his claim. One of the critics being a physician, it might be assumed that his opinions are founded on fact and that they represent the views of the rest of the profession, although such is not the case.

Just what are the facts? Are millions of people in this country suffering because of the lack of adequate medical care, or is this just another of the many mare's nests scared up from time to time by sympathetic but not especially well-informed people? I would define adequate medical care as the amount necessary to supply the needs of a community on a plane equal to that obtainable in similar communities in any other part of the world.

Ideal medical care would require the immediate application of the discoveries of medicine in the prevention and cure of disease. The facilities for the care of the sick enjoyed by all classes of people in America, although failing to reach the ideal, are nevertheless, superior to those of all other countries of the world. Undoubtedly, however, there are people who lack adequate medical care for various reasons such as religious prejudice, ignorance of available facilities, preference for cults and for self-medication, and in some instances because of the lack of financial resources. The implication that there are millions deprived of medical care because of poverty is open to question. The most recent

estimate of people on relief in the United States was eighteen million. The magnitude of the local problem is indicated by the fact that in February, 1933, 855,000 people in Cook county (Illinois) were on relief rolls.

If it be granted that the activities of the medical profession either in the fields of preventive or of curative medicine have, heretofore, operated to reduce the death rate, then it must be conceded that the withdrawal of these activities from millions of people might be expected to affect the mortality statistics adversely. The facts are, however, that within the past thirty-four years, with the exception of the year 1918, when the war and its associated epidemic diseases caused the death rate to rise to 18.1 per thousand of population, the rate has always been lower than it was in 1900.

It has not exceeded 16 deaths per thousand since 1905; 15 deaths per thousand since 1910; 14 deaths per thousand since 1917, with the exception of 1918. Between 1921 and 1929, the period of so-called prosperity, the rate remained close to 12 deaths per thousand. In 1930 the rate was 11.33; in 1931, 11.075; in 1932, 10.89; and in 1933, 10.70. The rate (9.7) for the city of Chicago for 1933 is the lowest ever recorded. We may conclude, therefore, that lack of adequate medical care has not been reflected in mortality statistics.

Other evidence could be cited, such as a 46 per cent increase in the patronage of the teaching clinics of Chicago, staffed by unpaid volunteer physicians, but it is felt that a decreasing death rate during a period of economic hardship is irrefutable proof that the charge is merely another canard. In connection with the falling death rate it is interesting to note that medicine has been called upon to render an additional amount of free service as a result of a 38 per cent greater birth rate among the unemployed than in a corresponding group of employed.

For a number of years there has been a great deal of criticism because of the high cost of medical care. Exhaustive reports have been published under the auspices of foundations and by national committees formed to study the problem. Much of value has been learned as a result of these efforts but so far no practical proposal for reducing the cost of medical care has been advanced. At one time many people favored the adoption of a mass-production industrial plan in the hope that thereby the cost of medical care might be reduced. The cry now is for socialized medicine by which the burden on the person who receives the care will be distributed over a group.

The criticisms directed against medicine frequently imply that physicians fatten on the misfortunes of their fellows. Statistics showing the annual net income of physicians over a period of years are not available. Those gathered by the committee on the costs of medical care for 1929 show an expenditure of $9 per capita for the services of private physicians. The average net income of private practitioners for that year was $5,467. It is, of course, much lower now.

There can be no doubt that the cost of medical care per patient has increased materially in recent years although the true cost is less. In

1900, adequate medical care was comparatively inexpensive as compared with what constitutes adequate medical care now. The increase in cost is due, however, more to the extension of medical knowledge and to the type of service rendered than to any increase in the income of physicians.

Modern medical care involves the expenditure of money for a great many things that are very essential in the prevention and cure of disease, but which do not directly benefit the physician in the least, and this is a point which should be kept clearly in mind. In 1929, physicians received 29.8 cents out of every dollar spent for medical care. Medical care includes the cost of hospitalization, nursing, drugs, anesthetics, anesthetic machines, methods for the induction of anesthesia without the inhalation of gases, dressings, fracture beds, splints, radium, X-ray treatment and diagnosis, serums, vaccines, oxygen tents and rooms, baby incubators, electro-surgical equipment, bacteriological, chemical, and pathological laboratories, electrocardiographs, inductotherms, diathermy and metabolism machines and a host of other things undreamed of in 1900. The familiar roentgen X-ray was discovered so recently as 1895.

Another not inconsiderable but very necessary item of expense in every large well-conducted hospital is the salary list of technicians, medical stenographers, dieticians and record clerks. The gradual increase in cost of hospital care of patients exclusive of medical fees is well illustrated by the following per diem costs of a well managed Chicago hospital: 1905, $1.94; 1910, $2.76; 1915, $2.59; 1920, $4.51; 1925, $6; 1930, $7.57; 1934, $6.99.

The progress of medicine is due to the fact that it has availed itself of every advance in the field of science so that diagnosis has become more exact and the results of treatment more certain. New facilities have added to the cost of illness, but their use has been justified by the results. It should be clear, therefore, that medical care is more expensive than formerly simply because more is given, and it should be equally clear that the cost of personal services of the physician has become an item of decreasing relative importance in the total costs of illness.

Medicine does not need to be reminded that this is not a static world. Physicians are in intimate daily contact with all classes of society and as a result they are quite alert to the social and economic changes of our times. They are aware of the fact that many people feel that the financial responsibility of the individual for personal medical care, with all that the term implies, must be shifted from the individual to a group. The real problem, therefore, is not that the American people have lacked for medical care but that they do not feel that the costs of illness when illness comes should be the obligation of the individual.

A very large number of people are entirely indigent and are more or less constantly dependent on society for food, clothing, housing, and medical care. For this group the local and state governments should without question accept full responsibility.

Another group is able to pay for food, clothing, shelter, automobiles, and amusements, but not for the costs of illness, because of the unpredictable nature of illness. For this group a plan is needed.

A third group is able by means of savings, insurance, or surplus capital to pay with varying degrees of ease for whatever they need, and therefore do not require and should not receive the assistance of society. The depression has, of course, greatly reduced the number in the latter group and increased the numbers in the first two groups.

Plans providing for the distribution of the costs of illness raise numerous important questions including those of whether the plan shall be national or local in scope and what the responsibility of medicine is. In the drafting of such a plan a major responsibility of the medical profession will be to see that the very superior facilities for the care of the sick which are now enjoyed by the people of this country, and which have given such satisfactory service during a period of great stress, are not sacrificed.

## THE COSTS OF MEDICAL CARE

(An editorial in Hygeia, volume 11, page 10, January, 1933.)

After five years of repeated meetings and after the publication of almost thirty studies of conditions related to the costs of medical care, a national committee has just published its final report. In that report it has recommended that medical service of all types be furnished largely by organized groups of doctors centered preferably around a hospital and that these doctors be paid by some system of group payment through the use of insurance or taxation or both. The majority of the committee also recommended the extension of basic health services, continued study of the economics of medical service, and changes in the nature of medical education leaning toward more preventive medicine.

At the same time a minority report was presented by leading physicians on the committee. These physicians object to the medical center plan because it contains evils which might be worse than the evils it is supposed to alleviate. They have seen, in communities where such centers have been established, competition leading to underbidding and skimping of medical service or else a medical dictatorship in which the rights of the patient are not likely to be respected. They feel that the continuous personal relationship of the physician and patient which is necessary for the best type of medical practice would not be possible under such conditions. Actually the minority group charges that the majority was biased through studying only the favorable aspects of group practice and that any attempt to put all medical practice on such a basis would actually multiply costs greatly without increasing efficiency.

Investigations that have been made by the commission on medical education show that more than 85 per cent of all the illness that afflicts mankind can be satisfactorily and most economically diagnosed and treated by a good general practitioner with the amount of equipment that he can carry in a handbag. Moreover, almost half of the practice of a physician is carried on in his office, about 35 per cent in the patients' homes and about 15 per cent in the hospitals. There would seem to be

no necessity for more extensive hospitalization, and an attempt to take care of disease through groups would tend to multiply costs rather than to decrease them. The minority report recommends that government competition in the practice of medicine be discontinued and that its activities be restricted to certain special services. Their primary recommendation, which naturally follows from the facts here mentioned, is that united attempts be made to restore the general practitioners to the central place in medical practice. The minority group and the physicians of this country in agreement therewith feel that methods which would change the nature of medical practice may be given careful trial if they can be rightly fitted into our present system.

The majority report of this committee on the costs of medical care is probably an outgrowth of that period of inflation which followed the World War and which was marked by excessive respect for efficiency systems, mass methods of manufacture, belief in the great god, "organization," and disregard for the individual. It seems likely that our present epoch of deflation will result in increased respect for the rights of the human being as such and a tendency to get away from any system of standardization that would try to fit all human beings into one category. The physicians of this country know that no two human beings are exactly alike and that when they are treated they must not be considered merely ailing human beings but also ailing human souls. They feel that the patient's person is more likely to receive proper consideration when he is responsible to his own doctor for the care that is given him and when his own doctor is responsible to him for the outcome of his illness. This is the platform on which the organized medical profession of this country is standing today. The services rendered by individual doctors in the aggregate constitute the great bulk of medical service. Quality is far more important in medical service than any other factor. For some thousands of years the medical profession has gained repute as the most ethical and altruistic profession of any that serves mankind. This record entitles it to consideration in any plan for changing its nature.

Already many leading newspapers of this country have expressed themselves in opposition to the schemes of socialization that have been proposed by the majority report of the committee on the costs of medical care. Indeed this opposition is so definite and the response of the newspapers represents so certainly what may be expected as the response of the people that the majority report will probably pass like the Wickersham report into innocuous desuetude.

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The H. W. Wilson Company has published a 190-page number of the Reference Shelf, volume 7, number 1, on the subject, "The Socialization of Medicine." Edith M. Phelps, compiler. Price, 90 cents. Address the H. W. Wilson Company, 958 University Avenue, New York, N. Y.

The H. W. Wilson Company has also published a 335-page number of the Reference Shelf, volume 10, number 5, on the subject, "Socialization of Medicine." Julia E. Johnsen, compiler. Price, 90 cents. Address the H. W. Wilson Company, 958 University Avenue, New York, N. Y.

Bower Aly has published the National University Extension Association's Debate Handbook for 1935-36, volume 1, entitled "Socialized Medicine." The handbook contains an annotated bibliography, a critical analysis of the national high school debate topic, articles prepared especially for the volume, and selected reprints from current sources. The handbook is 222 pages in length. Price, 75 cents. Address Bower Aly, University of Missouri, Columbia, Mo.

Bower Aly has also published the National University Extension Association's Debate Handbook for 1935-36, volume 2, supplement, entitled "Socialized Medicine." This supplement contains seven chapters as follows: "General Considerations Bearing on Socialized Medicine," "The Background of Socialized Medicine," "Arguments for Socialized Medicine," "Arguments Against Socialized Medicine," "The Economics of Medicine in Foreign Countries," "Alternative Plans for Medical Care," and "Medicine Today in the Several States." The supplement includes reprints designed to furnish a basis for a comprehensive view of the economic problems of medicine. The supplement is 222 pages. Price, 75 cents. Address Bower Aly, University of Missouri, Columbia, Mo.

With each order for the complete N. U. E. A. debate handbook (two volumes) referred to above, Mr. Aly will furnish free of charge, while the supply lasts, a set of valuable debate materials, each article or report of which could be obtained otherwise only through purchase. The titles included in this set of materials are: "Some Defects in Insurance Propaganda," "A Critical Analysis of Sickness Insurance," "Sickness Insurance Not the Remedy," "Sickness Insurance Catechism," "Medical Economics: Pollak Debate Handbook, No. 28, Revised," "Buying Health: a Special Number of the Survey Graphic for December, 1934," "Economic Aspects of Medical Services," "A Picture Book About the Costs of Medical Care," "Case Studies in the Costs of Medical Care," "The Ability to Pay for Medical Care," and "The American Approach to Health Insurance." A payment of $1.67 ($1.50 for the two volumes of the handbook, plus 17 cents for postage) must accompany each order.

Copies of the radio debate on the national high school debate topic may be secured from the Debate Committee, Box 209, Columbia, Mo. The speakers who participated in the debate, which was held on November 12, 1935, were: on the affirmative, W. T. Foster and Bower Aly; and on the negative, Dr. Morris Fishbein and Dr. R. G. Leland. The price is 15 cents for one copy or 25 cents for two copies.

Noble and Noble have published a 360-page debater's help book, edited by E. C. Buehler. Price, $2. Address Noble and Noble, Publishers, Inc., 100 Fifth Avenue, New York, N. Y.

The August-September, 1935, number of the Congressional Digest is devoted to the topic, "Should America Adopt the System of Socialized Medicine." Price, 50 cents. Address the Congressional Digest, 2131 LeRoy Place, Washington, D. C.

A 37-page issue, volume 2, number 2, 1934, of Editorial Research Reports has been published, devoted to the topic, "Sickness Insurance and Group Hospitalization." This number was prepared by Joel I. Seidman. Price, 75 cents. Address Editorial Research Reports, 1013 Thirteenth Street, N.W., Washington, D. C.

The Library of Congress has prepared a list of references on the subject, "Medical Care in the United States and Foreign Countries with Special Reference to Socialization: Selected Lists of Recent Writings." For this bibliography, the principal or debate coach should write the Library of Congress, Washington, D. C.

Materials on the debate subject may be secured from the following organizations: the Julius Rosenwald Fund, 4901 Ellis Avenue, Chicago, Ill.; the Bureau of Medical Economics of the American Medical Association, 535 North Dearborn Street, Chicago, Ill.; the Milbank Memorial Fund, 40 Wall Street, New York, N. Y.; the Twentieth Century Fund, 41 East 57th Street, New York, N. Y.; and the Pollak Foundation for Economic Research, Newton, Mass. The principal or debate coach should write to each of these organizations for a list of the materials offered, with the price charged.

The various reports, ranging from volume 1 through volume 28, of the committee on the costs of medical care may be purchased from the University of Chicago Press. Volume 27, entitled "The Costs of Medical Care" and volume 28, entitled "Medical Care for the American People: the Final Report of the Committee on the Costs of Medical Care" would be especially helpful to those who are studying the debate subject. For a price list of these publications, the principal or debate coach should write to the University of Chicago Press, 5750 Ellis Avenue, Chicago, Ill.

An arrangement has been perfected whereby school officials may secure from Bower Aly copies of volume 27, the summary volume of the report of the committee on the costs of medical care. The regular price of this publication is $4, but, while the supply lasts, it may be secured from Mr. Aly at the price of $2, plus 17 cents for postage. Orders for this publication should go direct to Bower Aly, University of Missouri, Columbia, Mo.

The Survey Graphic has published two special issues and two semi-

special issues in the field of the socialization of medicine. The two special issues are: "The Cost of Health," January 1, 1930; and "Buying Health," December, 1934. The semi-special issues are those for December, 1932, and April, 1934. These issues may be obtained at the price of 30 cents each from Survey Associates, Inc., 112 East 19th Street, New York, N. Y.

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EXTENSION BULLETIN

VOL. XV OCTOBER, 1935 NO. 3

# ACADEMIC CONTESTS FOR NORTH CAROLINA HIGH SCHOOLS

ANNOUNCEMENT FOR THE YEAR
1935-1936

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# ACADEMIC CONTESTS FOR NORTH CAROLINA HIGH SCHOOLS

## Announcement

Announcement is made in this number of the University of North Carolina Extension Bulletin of the regulations which will govern the following academic contests for North Carolina high schools, to be conducted in the spring of 1936: the twelfth annual high school Latin contest, the eleventh annual high school French contest, the eleventh annual high school Spanish contest, and the eleventh annual high school Mathematics contest.

By means of these contests the University Extension Division and the several departments concerned of the University of North Carolina hope to render a service to the high schools through an increase in the interest of North Carolina high school students in the field of scholarship, particularly in the study of the designated subjects, Latin, French, Spanish, and Mathematics. Since these contests were inaugurated, with the first annual high school Latin contest held on February 18, 1925, they have met with a very cordial reception on the part of the high schools of the State. The central committee at the University hopes that the contests will be found helpful by the high schools and that they will prove generally successful this year.

The dates for the holding of these different contests are as follows: Latin contest, February 21; French contest, March 6; Spanish contest, March 19; and Mathematics contest, April 24.

All accredited North Carolina public high schools are invited to enter the contests. The school officials whose schools plan to enter the contests should notify E. R. Rankin, Secretary, at Chapel Hill, at their earliest convenience regarding the participation of their high schools and regarding the number of pupils whom they will have to enter the different contests.

The attention of school officials and teachers is called to the following general regulations, which will apply to all four of the high school academic contests, and to the special regulations which will govern each particular contest.

## GENERAL REGULATIONS

1. The University Extension Division and the several departments concerned of the University of North Carolina will conduct, with the coöperation of participating high schools, contests in the spring of 1936 in Latin, French, Spanish, and Mathematics for high school students, participation in these contests being open to accredited North Carolina public high schools.

2. The contests will be conducted in all cases under the direct supervision of the superintendents, high school principals, or teachers in the schools.

3. No student who has already been graduated from a high school shall be eligible to participate in the academic contests.

4. It is necessary for all students to be regularly enrolled in their high schools at the time of their participation in the academic contests.

5. The tests in all of these contests will be forwarded from Chapel Hill to the individual schools in sealed envelopes, which are not to be opened until the time when the examinations are given.

6. It will be necessary in each case that the individual student give a pledge stating that no help has been given or received on the test.

7. Superintendents, principals, or teachers in charge of the contests will give assurance to the committee that the contests have been properly conducted and that all of the regulations and conditions pertaining to the contests have been observed.

## THE HIGH SCHOOL LATIN CONTEST

1. The contest will take place throughout the State on February 21, 1936.

2. Students who may take part in the Latin contest are limited to members of the sophomore, junior, and senior classes.

3. This examination will require (1) an ability to translate passages of comparatively easy Latin, will include (2) questions on form and syntax based on such passages, and will include (3) questions involving a general knowledge of grammar.

4. The individual school will select the best three papers from the total of the papers submitted in the local contest and will send these three papers to the Secretary of the Latin Contest Committee at Chapel Hill by February 28, 1936.

5. The papers, as they are sent in by the various high schools, will be graded by faculty members of the department of Latin of the University. Announcement will be made of the school whose student wins first place. Honorable mention will be given to several schools whose students submit next best papers.

6. All schools deciding to enter the contest will notify the committee at Chapel Hill not later than February 17 of their plan to participate and will also notify this committee as to the number of students of the particular high school who will wish to enter the contest.

## THE HIGH SCHOOL FRENCH CONTEST

1. The contest will take place throughout the State on March 6, 1936.

2. The high school French contest is intended only for students in second year French who have had no special advantages nor private instruction in the language.

3. The scope of the contest will include: (1) a vocabulary test, (2) the conjugation of several representative verbs, (3) the composing of French sentences illustrating different grammatical points, and (4) a reading test.

4. The individual school will select the best three papers from the total of papers submitted in the local contest and will send these three papers to the secretary of the French Contest Committee at Chapel Hill by March 13, 1936. *The high school teacher is expected to score and to record the number of errors in each paper which is sent to Chapel Hill. Papers which have not been scored and on which the errors have not been recorded will be automatically disqualified.*

5. The papers from the various high schools will be graded by faculty members of the department of French of the University. Announcement will be made of the three best individual papers in order of excellence, with honorable mention to the next twelve. Announcement will also be made of the three schools whose three-student teams make the best showing.

6. All schools deciding to enter the contest will notify the committee at Chapel Hill not later than March 2 of their plan to participate and will also notify this committee as to the number of students of the particular high school who will wish to enter the contest.

## THE HIGH SCHOOL SPANISH CONTEST

1. The contest will take place throughout the State on March 19, 1936.

2. Students who may take part in the Spanish contest are limited to the sophomore, junior, and senior classes. The contest will be of a practical nature, enabling the student to show what facility he has acquired in handling Spanish verbs, grammar, and reading.

3. The individual school will select the best three papers from the total of the papers submitted in the local contest and will send these three papers to the Secretary of the Spanish Contest Committee at Chapel Hill by March 27, 1936. *The high school teacher is expected to score and to record the number of errors in each paper which is sent to Chapel Hill. Papers which have not been scored and on which the errors have not been recorded will be automatically disqualified.*

4. The papers from the various high schools will be graded by faculty members of the department of Spanish of the University. Announcement will be made of the school whose student wins first place. Honorable mention will be given to several schools whose students submit next best papers.

5. All schools deciding to enter the contest will notify the committee at Chapel Hill not later than March 16 of their plan to participate and will also notify this committee as to the number of students of the particular high school who will wish to enter the contest.

## THE HIGH SCHOOL MATHEMATICS CONTEST

1. The high school Mathematics contest will take place throughout the State on April 24, 1936.

2. Students who may take part in the mathematics contest are limited to members of the sophomore, junior, and senior classes.

3. The scope of the contest will include: (1) an arithmetic test, (2) an algebra test, and (3) a plane geometry test.

4. The individual school will select the best paper from the total of papers submitted in the local contest and will send this paper to the Secretary of the Mathematics Contest Committee at Chapel Hill by April 30, 1936. Only one paper is to be sent to Chapel Hill from each school. Each paper submitted in the contest must carry the name of the writer, the name and address of the school, and the name of the principal.

5. The papers, as they are sent in by the various schools, will be graded by faculty members of the department of Mathematics of the University. Announcement will be made of the school whose student wins first place. Honorable mention will be given to several schools whose students submit next best papers.

6. All schools deciding to enter the contest will notify the committee at Chapel Hill not later than April 20 of their plan to participate and will also notify this committee as to the number of students of the particular high school who will wish to enter the contest .

## WINNERS OF ACADEMIC CONTESTS IN THE PAST

### THE LATIN CONTEST

The Charlotte High School, 1925
The Lillington High School, 1926
The Wilson High School, 1927
The Roxboro High School, 1928
The Durham High School, 1929
The Durham High School, 1930
The Durham High School, 1931
The Roxboro High School, 1932
The Wilson High School, 1933
The Durham High School, 1934
The Wilson High School, 1935

### THE FRENCH CONTEST

The Raleigh High School, 1926
The Davidson High School, 1927
The Forest City High School, 1928
The Lenoir High School, 1929
The Greensboro High School, 1930
The Fayetteville High School, 1931
The Louisburg High School (tie), 1932
The Sylva High School (tie), 1932
The Oxford High School, 1933
The Louisburg High School, 1934
The Louisburg High School, 1935

### THE SPANISH CONTEST

The Statesville High School, 1926
The Statesville High School, 1927
The Reidsville High School, 1928
The Albemarle High School, 1929
The Albemarle High School, 1930
The Fayetteville High School, 1931
The Gastonia High School, 1932
The Gastonia High School, 1933
The Gastonia High School, 1934
The Gastonia High School, 1935

### THE MATHEMATICS CONTEST

The Ayden High School, 1926
The Charlotte High School, 1927
The Ahoskie High School, 1928
The Rocky Mount High School, 1929
The Greensboro High School, 1930
The Greensboro High School, 1931
The Durham High School, 1932
The Durham High School, 1933
The Broughton High School, 1934
The Albemarle High School, 1935

## UNIVERSITY EXTENSION SERVICES

The University of North Carolina offers, through the Extension Division, the following services to the people of the State:

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**Extension Class Instruction.** Late afternoon, evening, and Saturday classes are organized wherever enough enrollments to cover expenses are secured. Courses of both a vocational and cultural nature are offered, with college credit, if desired.

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